



U. S. NAVY

**MANUAL OF
THE MEDICAL
DEPARTMENT**

NAVMED P-117

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(With Changes thru 100)

25 Sep 85

Change 99¹

Department of the Navy
Naval Medical Command
Washington, D.C. 20372-5120

1. The Manual of the Medical Department is issued in accordance with United States Navy Regulations article 1202. It concerns matters over which the Commander, Naval Medical Command exercises command, control, or supervision.
2. Designated articles of the Manual establish mandatory regulations that must be adhered to by all Medical Department commands and personnel. Violations of such articles are punishable in accordance with the Uniform Code of Military Justice. These mandatory regulations are marked "Regulatory."
3. Articles not designated "Regulatory" are for the guidance of commanding officers, officers in charge, and all other members of the Medical Department.


J. S. CASSELLS
Commander, Naval Medical Command

CHANGE 101
MANUAL OF THE
MEDICAL DEPARTMENT

2 Jul 87

To: Holders of the Manual of the Medical Department

1. This change

- a. Revises article 2-18(1)(c) to ensure legal accuracy.
- b. Revises Chapter 14, Section II, Navy Blood Program.
- c. Revises chapter 18:

(1) Article 18-8 allows changes in the composition of medical boards,

(2) Article 18-9 provides for additional activities to convene medical boards.

(3) Articles 18-10(3) (a) and (b) guarantee a member's right to separation under the proper provisions of law.

(4) Article 18-16, Providing Medical Information and Line of Duty/Misconduct Investigation Reports, is new.

(5) Article 18-18, Surgical Procedures on Members in the Disability Evaluation System, is new.

2. Action

a. Remove chapter 2, section IV; chapter 14, section II; and chapter 18. Replace with attached sections and chapter.

b. Record this Change 101 in the Record of Page changes.



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CHANGE 95
RECORD OF CHANGES

MANUAL OF THE MEDICAL DEPARTMENT, U.S. NAVY
(MANMED is being completely updated. Destroy previous Record of Changes.)

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Chapter 1

MEDICAL DEPARTMENT

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1-1. Definition

(1) The Medical Department of the Navy is composed of the Medical Corps, the Dental Corps, the Medical Service Corps, the Nurse Corps, the Hospital Corps, and the dental technicians. The Medical Department administers commands and facilities devoted to providing medical and dental services, including the Bureau of Medicine and Surgery (BUMED), activities under the command and/or support of BUMED, and the medical departments and dental departments of other major claimants and offices.

1-2. Chief, Bureau of Medicine and Surgery

(1) The following is quoted from OPNAV Instruction 5450.178A:

Mission: The Chief, Bureau of Medicine and Surgery (who is also the Surgeon General of the Navy), under the command of the Chief of Naval Operations, commands the Bureau of Medicine and Surgery and shore activities as assigned by the Chief of Naval Operations. He shall provide all professional and technical assistance requisite to safeguarding and promoting the health of the Navy and Marine Corps personnel, and he shall provide professional and technical guidance in

the care and treatment of sick and injured Navy and Marine Corps personnel and their dependents, and other personnel as authorized by law.

Functions: To accomplish this mission, the Chief, Bureau of Medicine and Surgery shall:

1. Provide medical and dental care and services as authorized by law or regulation in medical and dental activities under the command of the Bureau of Medicine and Surgery for Navy and Marine Corps personnel, other uniformed services personnel, their dependents, retired members and their dependents, eligible survivors of deceased members, Federal civilian employees, and other categories of persons authorized by law or regulation.
2. Provide for medical and dental care in non-naval facilities of Navy and Marine Corps personnel, other uniformed services personnel, their dependents, retired members and their dependents, eligible survivors of deceased members, Federal civilian employees, and other categories of persons authorized by law or regulation.
3. Accomplish matters pertaining to Marine Corps personnel in coordination with the Commandant of the Marine Corps.
4. Plan and program the health care resources provided by the Bureau through all medical and dental activities under its command, and support for other activities as may be assigned by the Chief of Naval Operations.
5. Act as the chief of the Medical Department of the Navy in the professional and technical supervision of medical and dental matters throughout the Department of the Navy.

6. Issue and maintain manuals and directives to promulgate Medical Department or Bureau policies and procedures on medical and dental professional, technical, and administrative matters.

7. Conduct medical and dental inspections of activities commanded by the Bureau and assist other immediate superiors in command in performing command inspections of medical and dental facilities and health related activities throughout the Navy and Marine Corps.

8. Provide professional and technical advice and assistance to the Chief of Naval Material, systems commands, Bureau of Naval Personnel, fleet commands, and other offices, commands, or agencies in the utilization of medical and dental manpower, facilities, equipment, and material requisite to full health care support for the Department of the Navy.

9. Provide professional and technical guidance over design, construction, and equipping of medical and dental facilities ashore and afloat in coordination with the Chief of Naval Material, the Commander, Naval Facilities Engineering Command, the Commander, Naval Ship Systems Command, and, when appropriate, the Commandant of the Marine Corps.

10. Provide professional and technical guidance over performance requirements, procurement, and utilization of medical, dental, and mortuary supplies and equipment by preparing and maintaining medical and dental allowance lists, by liaison with the Defense Supply Agency and the Naval Material Command, by providing representation on the Defense Medical Material Board, and by advising and assisting the Chief of Naval Operations and the Commandant of the Marine Corps in these matters.

11. Initiate and conduct research, development, test, and evaluation efforts in biological and medical sciences, behavioral and social sciences, life sciences, technology, health education and training, health manpower productivity, and operational medical support systems in response to approved Navy and Marine Corps RDT&E requirements.

12. Provide professional and technical guidance and assistance to the Navy and Marine Corps in the planning and conduct of research, development, test, and evaluation of weapons, aircraft, and support systems.

13. Evaluate the health aspects of the total shipboard, aircraft, and shore environment in coordination and cooperation with those responsible for design, specifications, and standards of spaces and equipment, and with the Board of Inspection and Survey and other appropriate officials.

14. Provide professional and technical guidance and assistance to the Navy and Marine Corps in establishing standards of environmental sanitation, industrial hygiene, and other measures for the prevention of illness or injury within the Department of the Navy; and provide preventive medicine and industrial hygiene programs necessary to safeguard and promote the health of members of the Department of the Navy and others for whom the Navy has responsibility.

15. Formulate and promulgate, in conjunction with the Commandant of the Marine Corps as to matters pertaining to Marine Corps members, policies, standards, procedures, and training material for the Decedent Affairs Program of the Department of the Navy.

16. Develop and recommend physical standards and examinations of persons for entrance and retention in naval service and for specialized duties.

17. Develop, amend, and make recommendations upon entrance qualifications of all applicants for the Medical, Dental, Medical Service, Nurse, and Hospital Corps, and dental technicians.

18. Plan for and supervise the professional education and training of officer and enlisted members of the Medical, Dental, Medical Service, Nurse, and Hospital Corps, and dental technicians; furnish professional and technical assistance to the Chief of Naval Personnel in matters relative to advancement in rating of enlisted hospital corpsmen and dental technicians; and provide for continuing appraisal of, and appropriate response to, changes in training requirements and advances in educational methodology.

19. Establish professional standards for clinical methods and procedures in medical and dental care, treatment, and services in the Department of the Navy, and in support of these standards, perform visits to commands.

20. Provide specialized programs and scientific and technical assistance in the medical allied sciences.

21. Furnish to higher authority information and budget estimates relating to research projects and programs, and assume such responsibilities as may be delegated by higher authority in connection with research and development programs.

22. Maintain the highest professional, technical, management, and military competence among the officer corps, enlisted corps, and civilian employees which it sponsors.

23. Maintain liaison with Government and civilian health organizations on matters of related interest.

24. Manage the Navy Blood Program as a component of the Military Blood Program.

25. Cooperate with and assist the other armed services in the delivery of health care to eligible beneficiaries as directed by higher authority.

26. Perform such other tasks as appropriate to the mission, or as may be assigned by the Chief of Naval Operations.

1-3. BUMED Organization

(1) *Chart.*—The Bureau organization is depicted on the following chart.

(2) The *Chief, Bureau of Medicine and Surgery* (Surgeon General of the Navy) is assisted and advised by the organizational entities shown on the chart whose responsibilities are briefed in the following organization statements.

(3) The *Deputy Chief, Bureau of Medicine and Surgery* ranks next to the Chief of the Bureau in authority in BUMED and the Medical Department. The Deputy shall have such authority and duties with respect to the Bureau and the Medical Department as the Chief of the Bureau may delegate or prescribe, and shall act with full responsibility and authority in the absence of the Chief of the Bureau.

(4) The *Inspector General, Medical* coordinates the BUMED portion of the Naval Command Inspection Program and inquires into and reports on professional, technical, and administrative matters affecting the efficient operation of the Medical Department.

(5) The *Executive Assistant* acts as the executive agent for the Chief and Deputy Chief, Bureau of Medicine and Surgery directing the management and coordination of the internal administration and work of the staff. Makes recommendations to the Chief and Deputy Chief on matters related to official and personal correspondence. Acts as the Chief, Bureau of Medicine and Surgery's liaison between offices of the Department of Defense, other Government and civilian agencies, field commands, and BUMED components on matters affecting the administration of the Navy Medical Department; advises and assists representatives of these organizations in the interpretation and application of Bureau policies; and provides guidance in the problem areas.

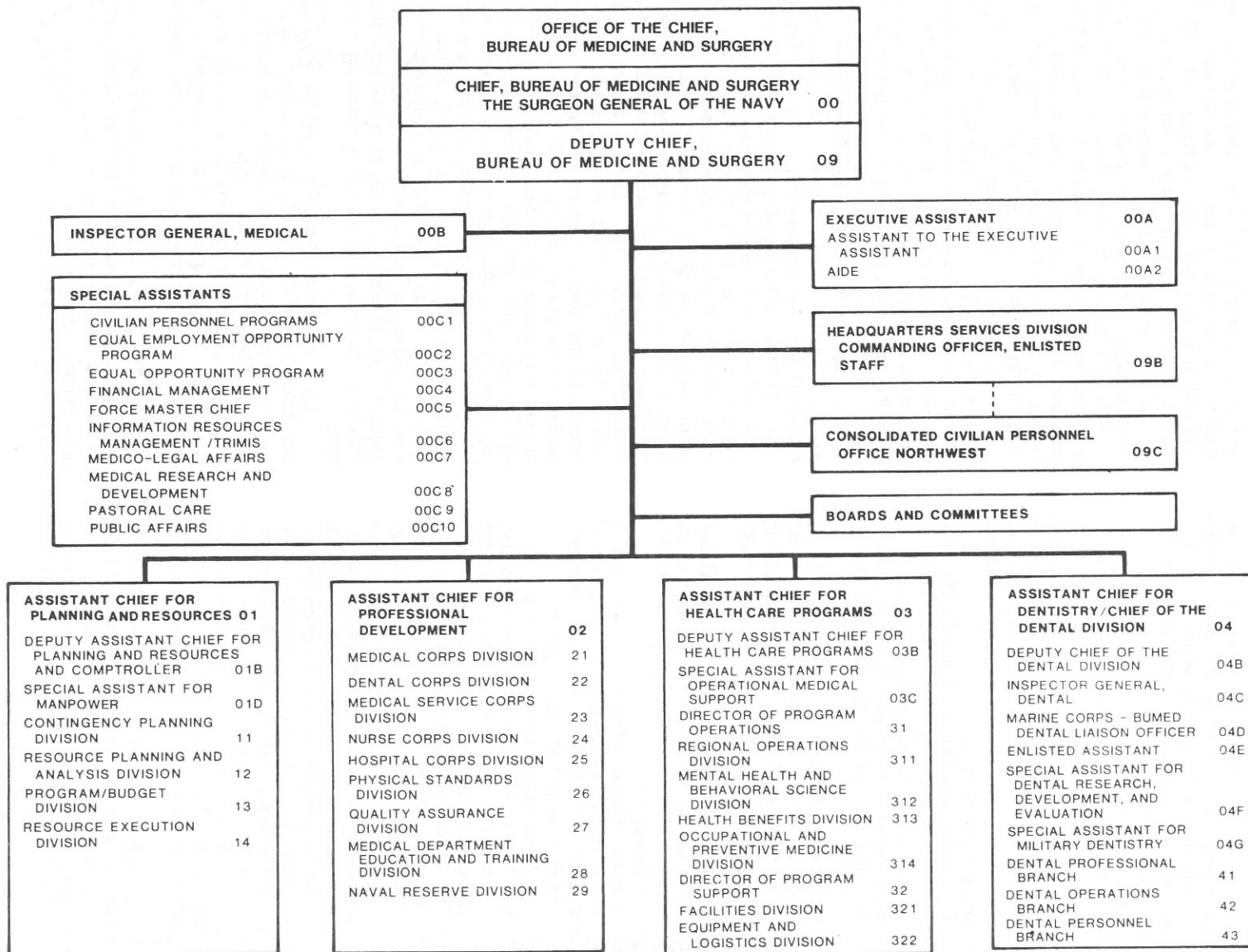
(6) *Headquarters Services Division/Commanding Officer, Enlisted Staff* provides centralized support in the areas of military and civilian human resource

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management, security, travel, communications, supply maintenance, printing, regulations and directives, and central records management. Initiates and coordinates proposals for improvements and reviews administrative practices and procedures within the Bureau of Medicine and Surgery to ensure compliance with policies and guidance of higher authority. Coordinates all official visits to the Bureau of Medicine and Surgery by higher authority. Serves as the commanding officer for enlisted personnel assigned to BUMED.

(7) The *Special Assistant for Civilian Personnel Programs* serves as advisor and consultant to the Chief, Bureau of Medicine and Surgery on command-wide civilian personnel management policies, operations, and programs.

(8) The *Special Assistant for Equal Employment Opportunity Program* acts as advisor and assistant to the Chief, Bureau of Medicine and Surgery in matters pertaining to equal employment opportunity (EEO) for civilian personnel of the Navy Medical Department.

(9) The *Special Assistant for Equal Opportunity Program* acts as advisor and assistant to the Chief, Bureau of Medicine and Surgery in matters pertaining to the Equal Opportunity Program for military personnel of the Navy Medical Department.

(10) The *Special Assistant for Financial Management* acts as special advisor and consultant to the Chief, Bureau of Medicine and Surgery in all matters of financial management.

(11) *Internal Review Division* conducts special audits, reviews, studies, analyses, and investigations of the management of all Medical Department Resources and the system of control of these resources.

(12) The *Force Master Chief* serves as advisor to the Chief, Bureau of Medicine and Surgery in matters related to members of the enlisted community (Hospital Corps personnel and dental technicians).

(13) The *Special Assistant for Information Resources Management/TRIMIS* manages the Navy Medical Department Information Resources Management and Tri-service Medical Information System (TRIMIS) programs. Acts as the program manager for information resources management (which includes automatic data processing, automatic office systems, telecommunications, and selected information systems) and acts as director of the Navy TRIMIS office. Advises on and recommends policy concerning the development of management information to the Chief and Deputy Chief of the Bureau. Acts as the Commanding Officer of the Naval Medical Data Services Center.

(14) The *Special Assistant for Medico-Legal Affairs* serves as legal consultant and advisor to the Chief and Deputy Chief, Bureau of Medicine and Surgery, other Bureau officials, boards and offices, and commanding officers of Medical Department

activities, and carries out special assignments given by the Chief of the Bureau.

(15) The *Special Assistant for Medical Research and Development* serves as the Executive for Navy Medical Department research, development, test, and evaluation programs and as advisor to the Chief, Bureau of Medicine and Surgery on matters concerned with the application of science and technology to the mission of the Navy Medical Department.

(16) The *Special Assistant for Pastoral Care* serves as advisor and assistant to the Chief, Bureau of Medicine and Surgery in matters related to religious activities in the Navy Medical Department and such other duties as may be appropriately assigned.

(17) The *Special Assistant for Public Affairs* informs Medical Department personnel, other members of the naval service, and the general public about the mission, programs, and activities of the Navy Medical Department. Advises the Chief, Bureau of Medicine and Surgery concerning the public information needs of the Medical Department.

(18) The *Assistant Chief for Planning and Resources* exercises centralized supervision and coordination of the program planning, study, and system effort to ensure the integration of contingency planning, resource planning and analysis, program development, budgeting, appraisal, and system development within the Bureau and the management echelons subordinate to the Chief, Bureau of Medicine and Surgery. Plans, directs, controls, and administers the financial management program of the Medical Department. Justifies and ensures optimum utilization of financial resources for the business administration of the Medical Department for the efficient delivery of health care. Assists in the development of support and reviews the medical requirements of general war plans and contingency plans and programs for their support. Analyzes, plans, programs, and budgets for all Medical Department military and civilian manpower. Provides the Chief, Bureau of Medicine and Surgery and staff with information to make decisions, to readily respond to the requirements of the Operating Forces, to manage medical activities efficiently, and to utilize resources effectively.

(a) The *Deputy Assistant Chief for Planning and Resources and Comptroller* serves as the principle advisor and assistant to the Assistant Chief for Planning and Resources for all cognizant matters. As Comptroller, promotes economy and efficiency in the management of Bureau financial affairs, departmental and field, through positive and progressive financial management programs.

(b) The *Special Assistant for Manpower* serves as the advisor to the Assistant Chief for Planning and Resources in the development of policy, planning, programming, budgeting, execution, requirements, and analysis for all Medical Department military and

civilian manpower. Maintains liaison within BUMED, and with the Chief of Naval Operations (OPNAV), the Naval Military Personnel Command (NMPC), the Commandant of the Marine Corps (CMC), and other Navy major claimants in all matters pertaining to Medical Department manpower.

(c) The *Contingency Planning Division* develops plans for medical support of general war and contingency operations. Evaluates and implements medical intelligence. Serves as the coordinating element for the Bureau of Medicine and Surgery in the provision of medical support to the Operating Forces and monitors the readiness of BUMED resources to meet contingency requirements. Oversees and administers the formulation of contingency and mobilization requirements of the Navy Medical Department. Develops and reviews plans to carry out the contingency and mobilization mission of the Medical Department. Provides an assessment of the current hard intelligence pertinent to medical support plans and operations. Reviews and revises Navy Medical Department capabilities and provides recommendations for program objectives memorandum in support of contingency and mobilization requirements. Monitors the overall readiness of the Navy Medical Department and provides current readiness capability statements. Coordinates Navy Medical Department programs to assure compatibility with overall Navy missions. Provides for the security of classified information pertaining to contingencies.

(d) The *Resource Planning and Analysis Division* develops, tests, and implements medical and dental plans to improve health care services and to achieve more effective and efficient utilization of health care resources. Investigates, reviews, analyzes, evaluates, and recommends innovations in the health care system.

(e) The *Program/Budget Division* develops and operates for the Bureau an integrated programming and budgeting system that is responsive to the Chief of Naval Operations (CNO), the Navy Comptroller (NAVCOMPT), the Office of the Secretary of Defense (OSD), the Office of Management and Budget (OMB), and Congress.

(f) The *Resource Execution Division* develops the expense operating budget for field commands. Operates prescribed systems capable of maintaining control of resources, evaluating performance, and providing Bureau managers with program data adequate for review and decisionmaking. Serves as Comptroller in the absence of the Comptroller.

(19) The *Assistant Chief for Professional Development* develops, maintains, and reviews professional qualifications for recruitment of Medical Department personnel and ensures close liaison with Navy Recruiting Command (NAVCUITCOM) on recruitment matters. Directs the personal, career, and professional development of all Navy Medical Department members. Participates in the development and maintenance of an effective personnel retention program

for military and civilian Medical Department personnel. Develops and maintains professional standards and programs designed to increase the quality of care at all levels within the Navy health care delivery system. Develops policy and monitors the execution of the appropriate mix of professional and paraprofessional personnel, both military and civilian, throughout the Navy health care delivery system. Directs the development and application of physical qualification standards for Navy and Marine Corps personnel. Directs the coordination of all aspects of the Navy Medical Reserve Program in accordance with overall Navy policy and the requirements of law. Provides technical assistance in professional matters to other Bureau of Medicine and Surgery components and to field activities. Serves as the official liaison between BUMED and its field activities and professional societies, schools, and associations on professional matters. Serves as the central point of coordination for the management of specialty consultants. Coordinates with other BUMED components to ensure long range policy planning requirements to keep abreast of technological advances in the health care system. Coordinates all above activities with the Assistant Chief for Dentistry.

(a) The *Medical Corps Division* promotes the development and maintenance of Medical Department programs and policies which support and sustain objectives as established by the Chief of Naval Operations and Chief, Bureau of Medicine and Surgery. Develops, coordinates, evaluates, advises, monitors, and represents the Medical Department on policies, plans, and requirements affecting the Medical Corps. Plans for and recommends standards of medical practice, concepts, and methods for the delivery and evaluation of quality health care services. Studies and advises, in consultation with specialty advisors, the Assistant Chief for Professional Development on matters of procurement, selection, training, utilization, assignment, distribution, career development, and disposition of Medical Corps officers and physician's assistants. Implements the policies of the Chief, Bureau of Medicine and Surgery as they relate to Medical Corps officers, the practice of medicine, and physician's assistants.

(b) The *Dental Corps Division* provides coordination of professional matters between the Dental Division and the Assistant Chief for Professional Development, on a collateral duty basis.

(c) The *Medical Service Corps Division* promotes the development and maintenance of Medical Department programs and policies which support and sustain objectives as established by the Chief of Naval Operations and the Surgeon General. Develops, coordinates, evaluates, advises, and monitors policies, plans, and requirements affecting the Medical Service Corps. Develops and recommends professional standards and implements the policies of the Chief, Bureau of Medicine and Surgery, as related to the Medical Service Corps. Advises, in consultation with the

specialty advisors, the Assistant Chief for Professional Development on matters of procurement, retention, training, assignment, distribution, and disposition of Medical Service Corps officers.

(d) The *Nurse Corps Division* promotes the development and maintenance of Nurse Corps programs and policies which support and sustain Medical Department mission objectives as established by the Chief of Naval Operations and the Surgeon General. Develops, coordinates, evaluates, advises, monitors, and represents the Medical Department position on policies and requirements for all programs affecting the Nurse Corps. Plans for and recommends standards of practice, concepts, and methods for the delivery and evaluation of quality patient care. Studies and advises, in consultation with specialty advisors and the Assistant Chief for Professional Development, on matters of procurement, retention, training, assignment, distribution, disposition, and career development of Nurse Corps officers. Implements the policies of the Chief of the Bureau as they relate to nurses and nursing.

(e) The *Hospital Corps Division* monitors, evaluates, and analyzes all programs, plans, and policies which affect the Hospital Corps. Represents the Hospital Corps in the formulation of programs, plans, and policies within the Bureau of Medicine and Surgery. Establishes liaison with and represents the position of the Medical Department to those organizations outside the Medical Department which formulate, establish, or manage programs, plans, or policies which affect the Hospital Corps.

(f) The *Physical Standards Division* develops and administers primary accession and other physical standards and policies for Navy and Marine Corps personnel. Develops policy governing the interpretation and application of these standards for direct appointment and enrollment in officer training programs of the Navy and Marine Corps. Controls waiver policies for acceptance into the Navy and Marine Corps, Regular and Reserve. Promulgates changes in physical standards, or policies regarding application of such standards, in keeping with the current needs of the naval service.

(g) The *Quality Assurance Division* directs and coordinates the development and maintenance of professional standards and programs which are designed to increase the quality of care and reduce risk at all levels within the Navy health care delivery system. Assists in monitoring the performance of the systems and assists, when necessary, to effect corrective action. Maintains professional contact with the Joint Commission on Accreditation of Hospitals (JCAH) and assists medical treatment facilities in the interpretation of JCAH standards. Provides professional management guidance to the Assistant Chief for Professional Development in the area of quality assurance and risk management.

(h) The *Medical Department Education and Training Division* develops and administers the edu-

cation and training programs of the Medical Department for the professional development of all personnel. Develops policy, directs course selection and development, monitors, advises, assists, and evaluates all matters relating to the education and training of personnel. Coordinates new or changed requirements of the Medical, Dental, Medical Service, Nurse, and Hospital Corps with the Naval Health Sciences Education and Training Command.

(i) The *Naval Reserve Division* coordinates all aspects of the Reserve Program for all corps of the Navy Medical Department. Apprises, advises, and assists the Assistant Chief for Professional Development in all matters concerning the Navy Medical Department Reserve assets. Interfaces with the Contingency Planning Division of the Assistant Chief for Planning and Resources to ascertain mobilization requirements and identify Reserve assets and capabilities.

(20) The *Assistant Chief for Health Care Programs* provides integrated management and direction of the various Navy Medical Department components providing direct medical and health care services.

(a) The *Special Assistant for Operational Medical Support* develops, projects, and coordinates programs relating to Navy and Marine Corps operational medical support and serves as liaison between the Bureau of Medicine and Surgery, OPNAV, and other Department of Defense (DOD) operational components in matters involving medical care for the Operating Forces. Provides continual appraisal of all programs which affect operational medicine and makes recommendations to the Assistant Chief for Health Care Programs on methods for improving the medical care of members of the Navy and Marine Corps Operating Forces. Provides liaison with the Contingency Planning Division in all matters involving health care operations.

(b) The *Aerospace Medicine Division* advises the Special Assistant on, and assures the development, projection, and direction of all Medical Department programs relating to Navy and Marine Corps aerospace medical support.

(c) The *Undersea and Radiation Medicine Division* develops and projects undersea and radiation medical policies, standards, doctrines, practices, and procedures. Directs Medical Department programs relating to physical qualifications, selection, and training of submarine, diving, and radiation medical personnel. Advises on and coordinates all phases of undersea and radiation medicine.

(d) The *Surface/Sealift Medicine Division* coordinates, monitors, and supports the delivery of medical and health care services to surface ships of the Military Sealift Command of the Navy.

(e) The *Marine Corps Medical Liaison Division* studies, evaluates, and advises on amphibious and Fleet Marine Force medical needs, policies, standards, practices, and procedures. Provides translation of the plans, policies, and doctrine of higher authority to the Fleet Marine Force environment. Develops

procedures and monitors execution of these procedures regarding amphibious assault, Fleet Marine Force operations, and field medicine aspects.

(f) The *Director of Program Operations* coordinates, monitors, and supports the delivery of medical and health care services within BUMED managed activities and other naval medical facilities.

(g) The *Regional Operations Division* serves as the Headquarters focal point for all day-to-day communications with BUMED managed and other naval medical treatment activities. Directs and coordinates all medical and health care administration programs, food service management systems, the Navy Blood Program, and Medical Department safety.

(h) The *Mental Health and Behavioral Science Division* develops, coordinates, and provides professional management guidance to the Assistant Chief for Health Care Programs through the Director of Program Operations in the utilization of Medical Department personnel management and implementation of mental health and behavioral science programs. Manages and coordinates BUMED special programs including, but not limited to, alcoholism, drug abuse, family advocacy, and the care of returned prisoners of war.

(i) The *Health Benefits Division* is responsible for the administration of: (a) The Uniformed Services Health Benefits Program; (b) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); (c) the Decedent Affairs Program; (d) hospitalization and health benefits in other than Navy facilities for active duty naval members and others so entitled; and (e) selective areas of patient administration matters. The latter includes eligibility for hospitalization and benefits; the transfer of patients and coordination of their movement with the Armed Services Medical Regulating Office; arrangements for the admission and treatment of special category patients such as foreign nationals, high U.S. Government officials, and persons authorized admission by the Secretary of the Navy; responding to congressional and other correspondence and inquiries pertaining to programs and patient relations; and facilitates other health care management matters.

(j) The *Occupational and Preventive Medicine Division* plans, develops, and manages programs to reduce the short and long-term risks of disease and injury for active duty Navy and Marine Corps personnel, Navy civilian employees, and others for whom the Navy Medical Department has responsibility. Accomplishes objectives through the promotion of health and by the identification and elimination or control of biological, chemical, and physical health hazards in all operating environments.

(k) The *Director of Program Support* develops plans for health care support and associated facilities requirements and prepares recommendations concerning scope, location, design, construction, and management relative to Medical Department shore facilities. Implements and coordinates planning,

programming, and budgeting for military construction; Operation and Maintenance, Navy; and Other Procurement, Navy under BUMED cognizance.

(l) The *Facilities Division* develops health care and support facilities requirements and maintenance, repair, and construction programs for the Medical Department. Prepares recommendations concerning scope, location, design, construction, and maintenance of Navy Medical Department facilities. Serves as the focal point for facilities construction and management relative to Medical Department shore facilities. Provides information for use in the planning and programming of replacement shore facilities.

(m) The *Equipment and Logistics Division* exercises centralized supervision and coordination of the Bureau's planning, programming, and budgeting for equipment and logistic support, except for those areas elsewhere assigned.

(21) The *Assistant Chief for Dentistry/Chief of the Dental Division* directs, develops, supervises, and coordinates all dental programs as the Chief of the Dental Division. Is responsible for continual appraisal of all programs over which cognizance has been assigned.

(a) The *Inspector General, Dental* plans, coordinates, and conducts inspections and visits of dental facilities in shore (field) activities and reports upon all matters which affect the efficient operation of the dental care program. Serves as the assistant to the Chief of the Dental Division and in the absence of the Chief, acts with full responsibility and authority.

(b) The *Deputy Chief of the Dental Division* ranks next in authority to the Chief of the Dental Division and the Inspector General, Dental and acts with full responsibility and authority in their absence. Is responsible for the projection of the policies of the Chief of the Dental Division and for the internal management of the Division.

(c) The *Dental Professional Branch* recommends policies, prepares directives, and acts upon correspondence pertaining to the general and specialty practices of dentistry within the Navy. Recommends and coordinates preventive and safety concepts related to the practice of dentistry. Serves as the primary dental advisory agent for the interpretation of Navy physical standards and the documentation of dental diseases and treatment. Studies, evaluates, and makes recommendations relative to policies governing officer and enlisted dental education and training, and dental technician rating personnel programs.

(d) The *Dental Operations Branch* advises the Chief of the Dental Division on matters related to dental finances, materiel, logistics, organizations, statistics, and dental facility planning. Provides technical assistance on dental equipment matters. Serves as the Navy's dental consultant to the Defense Medical Materiel Board.

(e) The *Dental Personnel Branch* acts as the principal advisor to the Assistant Chief for Dentistry on all personnel and policy matters, other than

assignment, relative to the Dental Corps. Reviews, evaluates, and makes recommendations on policies, procedures, and actions associated with Dental Corps programs and identifies and monitors Dental Corps personnel policy incentives and their impact on recruitment and retention objectives. Plans, coordinates, and directs the administration of all aspects of the Naval Dental Reserve Program.

1-4. Commanding Officers of Medical Department Activities

(1) A Medical Corps, Dental Corps, or Medical Service Corps officer, as appropriate, is assigned as commanding officer or officer in charge of each activity over which BUMED has command. The commanding officer or officer in charge is responsible for the direction and coordination of all functions of the activity, subject to U.S. Navy Regulations, the orders and instructions of BUMED, and those of other competent authority.

1-5. Heads of Medical Departments and Dental Departments of Ships and Stations

(1) The medical officer and the dental officer of a naval activity are responsible to the commanding of-

ficer for the medical and dental services, respectively, of that activity. The functions of the medical and dental departments of a naval activity are administered by the Medical Corps, Dental Corps, Medical Service Corps officers and their staffs in accordance with U.S. Navy Regulations, this manual, BUMED directives, and the orders and instructions of the commanding officer and competent higher authority.

1-6. Personnel

(1) The Medical Department includes the Medical Corps, Dental Corps, Medical Service Corps, Nurse Corps, warrant officers (PA), Occupational Field XIV Hospital Corps and dental technicians. Each corps is composed of personnel specialized appropriately to perform the designated duties for that corps. The medical, dental, and related services and health programs for which the Medical Department is responsible are carried out by the personnel of the several corps, dental technicians, and civilians in BUMED and in the field.

1-7. Offices of Medical and Dental Affairs

(1) See article 2-22 for offices of medical affairs and article 6-54 for offices of dental affairs.

Section II. NOMENCLATURE, DEFINITIONS, AND JOINT USE

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1-10. General

(1) Medical treatment facilities of the Department of the Navy are classified as either fixed or nonfixed. To determine the precise relationship of the number of patients to the number of beds, various classifications of beds and bed status are utilized.

1-11. Fixed Medical Treatment Facilities

(1) *Facilities.*

(a) SECNAVINST 6320.19A of 7 August 1978 is quoted in part below:

1. Purpose. This regulation provides (a) uniform nomenclature and definitions applicable to the classification of fixed medical treatment facilities, and (b) provides standard nomenclature and definitions for use in accounting for bed capacity, bed status, bed occupancy, patient accountability, and for length of patient stay review. This regulation implements DOD Instruction 6015.1 of 22 September 1977.

2. Policy

a. *Fixed Medical Treatment Facility Nomenclature and Definitions.* In consonance with DOD Instruction 6015.1, fixed medical treatment facilities shall consist of three basic types—medical centers, hospitals, and clinics, which are defined herein. In accounting for bed capacity, bed status, bed occupancy, and patient accountability in fixed medical treatment facilities, the nomenclature and definitions prescribed by the Department of Defense and set forth in this regulation shall be used.

* * * * *

3. Definitions of Termsa. *Fixed Medical Treatment Facilities*

(1) *Medical Center.* A medical center is a large hospital which has been so designated and appropriately staffed and equipped to provide health care for authorized personnel, including a wide range of specialized consultative support for all medical facilities within the geographic area of responsibility. Additionally, a medical center, when designated, conducts post graduate education in health professions.

(2) *Hospital.* A health treatment facility capable of providing definitive inpatient care. It is staffed and equipped to provide diagnostic and therapeutic services in the field of general medicine and surgery, preventive medicine services, and has the supporting facilities to perform its assigned mission and functions. A hospital may, in addition, discharge the functions of a clinic.

(3) *Clinic.* A health treatment facility primarily intended and appropriately staffed and equipped to provide emergency treatment and ambulatory services. A clinic is also intended to perform certain nontherapeutic activities related to the health of the personnel served, such as physical examinations, immunizations, medical administration, and preventive medicine services necessary to support a primary

military mission. A clinic may be equipped with beds for observation of patients awaiting transfer to a hospital, and for care of cases which cannot be cared for on an outpatient status, but which do not require hospitalization. Such beds shall not be considered in calculating occupied bed days by hospitals.

(b) *Administrative Titles.*—To differentiate between the various administrative types of medical centers, hospitals, and clinics, the following titles shall be used:

(1) *Naval Regional Medical Center or Naval Hospital (Location)* for a medical center or hospital that is an established shore (field) activity with a commanding officer, under the command and support of BUMED.

(2) *Naval Regional Medical Clinic (Location)*, for a clinic that is an established shore (field) activity with a commanding officer, under the command and support of BUMED.

(3) *Branch Clinic (Activity, Location)*, for a clinic, assigned to a BUMED command activity, that is located at and supports an activity under a bureau or office other than BUMED.

Note.—The titles of activities located outside the United States are preceded by the abbreviation U.S.

(2) *Beds.*—SECNAVINST 6320.19A of 7 August 1978 is quoted in part below:

b. *Bed Capacity*

(1) *Normal Bed Capacity*, or capacity for normal peacetime use, is space for patients' beds and is measured in terms of the number of beds which can be set up in wards or rooms designed for patients' beds and spaced approximately 100 to 120 square feet per bed. This definition refers only to space and excludes equipment and staff capability.

(a) For cantonment-type hospitals still in use, bed capacity may be measured in beds spaced on 8-foot centers. Former ward or room space which has been disposed of or has been so altered that it cannot be readily reconverted to ward or room space is not included in computing bed capacities.

(b) Space for beds used only in connection with examination or brief treatment periods, such as that in examining rooms or in the physiotherapy department, is not included in this figure. Nursery space is not included in the bed capacity but is accounted for separately in terms of the number of bassinets it accommodates.

(2) *Expanded Bed Capacity* is space for patients' beds and is measured in terms of the number of beds which can be set up in wards or rooms designed for patients' beds, spacing beds on 6-foot centers (approximately 72 square feet per bed). Former ward or room space which has been disposed of

or has been so altered that it cannot be readily reconverted to ward or room space is not included in computing bed capacities. Space for beds used only in connection with examination or brief treatment periods, such as that in examining rooms or in the physiotherapy department, is not included in this figure. Nursery space is not included in the bed capacity but is accounted for separately in terms of the number of bassinets it accommodates. This definition refers only to space and excludes equipment and staff capability.

c. *Bed Status*

(1) *Operating Bed.* A bed that is currently set up and ready in all respects for the care of a patient, it must include supporting space, equipment and staff to operate under normal circumstances. Excluded, are transient patients' beds, incubators, bassinets, labor beds and recovery beds.

(2) *Inactive Bed.* A bed that is ready in all respects—except for the availability of supporting medical staff—for the care of a patient; that is, space and equipment have been provided but the bed is not staffed to operate under normal circumstances. The bed need not necessarily be set up.

(3) *Transient Patient's Bed.* A bed that a designated medical center or hospital operates for the care of a patient who is being moved between medical treatment facilities and who must stop over for a short period of time while en route to his final destination.

(4) *Operating Bassinet.* A bed designed for the care of an infant that is currently set up in the newborn nursery and ready in all respects for use. It must include support space, equipment and staff to operate under normal circumstances. Excluded are infant transporters.

(5) *Inactive Bassinets.* A bed designed for the care of an infant that is ready in all respects except for the availability of supporting medical staff; that is, space and equipment have been provided but the bassinet is not staffed to operate under normal circumstances. The bassinet need not necessarily be set up.

d. *Bed Occupancy*

(1) *Occupied Bed.* A bed assigned to a patient as of midnight to include a patient on pass or liberty not in excess of 72 hours, and any bassinet assigned to a newborn infant. As an exception to the foregoing, a bed assigned to a patient who was admitted and discharged the same day will also be counted as an occupied bed. The definition excludes: any bed assigned to a patient subsisting out, on leave, or absent without leave; and any bed occupied by a transient patient.

(2) *Bed Occupied by Transient Patient.* A bed assigned as of midnight to a patient who is being moved between medical treatment facilities and who stops over while en route to this final destination.

e. *Patient Classification*

(1) *Inpatient.* An inpatient is an individual, other than a transient patient, who is admitted (placed under treatment or observation) to a bed in a medical treatment facility which has authorized or designated beds for inpatient medical or dental care.

(2) *Outpatient.* An outpatient is an individual receiving health services for an actual or potential disease or injury that does not require admission to a medical treatment facility for inpatient care.

(3) *Transient Patient.* A patient en route from one medical treatment facility to another medical treatment facility.

(4) *Quarters Patient.* An active duty uniformed service member receiving medical or dental treatment for a disease or injury that is of such nature that, on the basis of sound professional judgment, inpatient care is not required. The quarters patient is treated on an outpatient basis and normally will be returned to duty within a 72-hour period. The quarters patient is excused from duty past 2400 hours of the current day while under medical or dental care and is permitted to remain at home, in quarters, or in clinic observation beds.

(5) *Unauthorized Absentee Patient.* A patient who is either in an unauthorized absentee status, in the case of

active duty, or the non-active duty patient who has left without permission.

f. *Inpatient Actions*

(1) *Admission.* The act of placing an individual under treatment or observation in a medical center or hospital. The day of admission is the day on which the medical center or hospital makes a formal acceptance of the patient who is to be provided with room, board, and continuous nursing service in an area of the hospital where patients normally stay at least overnight. If both an admission and discharge occur on the same day, then that day is considered as a day of admission and shall be counted as one occupied bed day. The admission of a newborn is deemed to occur at the time of birth.

(2) *Disposition.* The removal of a patient from a medical center or hospital by reason of discharge to duty, to home, transfer to another medical treatment facility, death, or other termination of inpatient care. The day of discharge is the day on which the medical center or hospital formally terminates the period of inpatient hospitalization.

g. *Inpatient Accounting Terms*

(1) *Sick Days.* The total number of days from date of admission to the date of disposition. The day of admission is counted as a sick day and the day of disposition is not counted (exception: see admission/discharge on the same day in "Occupied Bed Day" below).

(2) *Occupied Bed Days.* With the exception of paragraph (d) below, an occupied bed day is defined as a day in which a patient occupies a bed at the census taking hour (normally midnight). The following are counted as occupied bed days:

(a) Days on pass or liberty not in excess of 72 hours.

(b) Newborn infant days while occupying a bassinet.

(c) Days in the labor or delivery room.

(d) Additionally, an occupied bed day is credited whenever a patient is admitted and discharged on the same day.

Where the patient occupies a bed in more than one inpatient care area in one day, the inpatient (occupied bed day) shall be counted only in the inpatient care area in which the patient is located at the census-taking hour.

(This definition excludes days during which the inpatient is subsisting out, on convalescent leave, on authorized or unauthorized leave, on pass in excess of 72 hours, or in a transient status.)

(3) *Subsisting Out.* The nonleave status of an inpatient who is no longer assigned a bed. Those days are not counted as occupied bed days but are counted as sick days. Inpatients authorized to subsist out are not medically able to return to duty but their continuing treatment does not require a bed assignment.

(4) *Convalescent Leave.* An authorized leave status granted to active duty uniformed service members while under medical or dental care which is a part of the care and treatment prescribed for member's recuperation or convalescence. These days are not counted as occupied bed days but are counted as sick days when the convalescent leave occurs prior to disposition of the patient. Convalescent leave occurring after disposition of the patient while en route to a new command, or convalescent leave granted by a line commander after patient discharge from the hospital is not counted as occupied bed days or sick days.

(5) *Length of Patient Stay.* The number of occupied bed days from the date of admission to the date of disposition.

4. *Other Definitions*

a. *Visit.* Each time an eligible beneficiary presents himself to a separate, organized clinic or specialty service for examination, diagnosis, treatment, evaluation, consultation,

counseling, medical advice; or is treated and/or observed in his quarters; *and* a signed and dated entry is made in the patient's health record or other record of medical treatment (see Note 1), then a visit is considered to have been completed and is countable. However, with the exception that consecutive clinic visits to specialty clinics, i.e., physical therapy and occupational therapy, will not require a signed and dated record entry at each visit unless there is a change in the prescribed treatment or a significant physical finding is evident. In all instances, however, an acceptable record audit trail shall be maintained. For example, a clinic log or treatment card may be maintained as a source document to support an audit trail.

(1) Classification of a service as a visit shall not be dependent upon the professional level of the person providing the service (includes physicians, nurses, physicians' assistants, medical specialists, and medical technicians). Further, the definition "Occasion of Service" shall be carefully considered to assure that credit for a visit is not extended where in fact the criteria for "visit" as set forth in Note 1 is not satisfied.

(2) A patient seen at the primary care clinic and two other specialty clinics on the same day is reported as three visits. A patient visiting a clinic in the morning and again in the afternoon shall count as two visits (providing the requirements of Note 1 are satisfied). These rules apply even if the patient is admitted as an inpatient immediately following a visit. Conversely, double counting shall be avoided; for example, a visit during which both a physician and a medical technician in the same clinic have been involved shall count as only one visit. Other examples of patient/medical care contacts which *shall* be included and counted as visits are:

(a) Each time a patient is seen who has been referred to a clinic or specialty service by another facility. (If the person is an inpatient of the referring facility, he/she shall be counted as an outpatient.)

(b) Each time a patient is seen, even though he/she may be referred elsewhere for admission.

(c) Each time a patient is seen in the emergency room, primary medical care area, or other designated area outside of regularly established clinic hours.

(d) Each time medical advice or consultation is provided by telephone if properly documented in the health care records. (See Note 1.)

(e) Each time all or part of a complete physical examination or flight physical examination is performed in a separately organized clinic, specialty service, or general outpatient clinic. Under this rule, one complete physical examination requiring the patient to be examined or evaluated in four different clinics is reported as four visits.

(f) Each time a therapist provides primary care (e.g., patient assessment while serving in a physician extender role) and then refers a patient for specialized treatment in that same clinic, then one visit for primary care and one visit for treatment shall be counted.

(g) Each time contact is made by clinic or specialty service members (other than primary physician) with patients on hospital wards, when such services are scheduled through the respective clinic or specialty service. (See Note 2.) For example, a physical therapist being requested by the attending physician to initiate certain therapy regimens to a patient who is in traction and unable to go to the clinic, or a dietitian requested to come to the bedside of a strict bed patient to explain and delineate a particular diet. Conversely, a physical therapist or a dietitian making routine ward patient visits shall not be countable as a visit.

(h) Each time an examination, evaluation, or treatment is provided in the home, school, community center, or other location outside of the medical treatment facility by a health care provider paid from appropriate funds.

(i) Each time one of the following tasks is performed when not a part of routine medical care, and the visit is associated with or related to the treatment of a patient for a specific condition requiring followup or to a physical examination and the provisions of Note 1 are completed with:

Therapeutic or desensitization injections.

Cancer detection checks (example: PAP smears).

Blood pressure checks.

Weight checks.

Prescription renewals (do not include refills).

(j) For group therapy sessions, count each patient attending as one visit regardless of the length of the session or the number of health care personnel involved (example: psychologists, psychiatrists, social workers, dietitians) in conducting the group therapy session *and* the provisions of Note 1 are satisfied. Conversely, group activity counseling (prospective parents classes, group instruction in first aid, and other sessions of this type) will be reported as one visit regardless of the number of participants, when individual treatment, examination, evaluation, or therapy is not provided.

(k) Each time a screening physical examination is performed (example: school, sport, employment and other like examination) providing an appropriate medical record entry is made (see Note 1).

b. *Nonvisits.* Do not report the following as visits:

(1) Occasions of service such as prescriptions filled by the pharmacy, chest X-ray surveys/examinations, laboratory tests, immunizations, or other diagnostic tests that are not a part of a specific treatment.

(2) Furnishing of medical advice or information, either directly or by telephone that does not satisfy the requirements of Note 1.

(3) Visits made to a school health program not staffed by Armed Forces health care personnel are not considered to be visits made to a separate clinic or specialty service. However, dependent children seen by employees of the medical facility such as Public Health Nurses are counted as visits (see Note 1).

(4) Visits at which treatment is rendered by providers paid from nonappropriated funds shall not be included in outpatient work load: which support appropriated fund requirements.

(5) Visits to functions listed in the Special Programs section shall not be counted as visits to any of the Ambulatory Care accounts. Also, such visits shall not be used in any cost assignment process for the Ambulatory Care accounts.

Note 1: The key to reporting visits is adequate documentation on appropriate medical records, e.g., SF 600, SF 513, OT&PT records of treatment to support an audit trail. For example, "refill prescription for birth control pills" with date and signature of the health care provider is not sufficient. The entry should indicate that discussion of use of pills and counseling did take place, for example, "discussed with patient; no apparent problem with use—patient advised to have a PE and PAP prior to next request for renewal; 6 months prescription for ovulen given."

Note 2: Visits of inpatients to Ambulatory Care Work Centers shall be separately identified from the visits of outpatients.

c. *Immunizations.* Count each injection or "dose" of an immunizing substance as an immunization, whether or not it completes a series. Count as only one immunization the double and triple immunizations given in a single injection, e.g., DPT, flu.

d. *Complete Physical Examination.* Record the total number of persons given complete physical examinations

(except flight physicals which are counted separately) such as annual, enlistment, reenlistment, appointment, promotion, requirement, periodic temporary disability retired list (TDRL) evaluations, and similar examinations. Visits made to various clinics incident to the physical examination shall be counted as visits in addition to this selective reporting.

c. *Occasion of Service.* A specific identifiable act of service involved in the medical care of a patient which does not require the assessment of the patient's condition nor the exercising of independent judgment to the patient's care (examples: a technician drawing blood, taking an X-ray, or administering an immunization). Issuance of medical supplies and equipment, i.e., colostomy bags, hearing aid batteries, wheel chairs, and hemodialysis supplies are specific examples of occasions of service and shall not be counted as visits. Pharmacy, Pathology, Radiology, and Special Procedures Services are occasions of service and are not counted as visits.

f. *Live Birth.* The complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy which after such separation, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each such product of such a birth is considered liveborn.

g. *Fetal Death.* Death occurring prior to the complete expulsion or extraction from the mother of a product of conception of 20 weeks or more gestation, or fetal weight of 500 grams or more.

1-12. Nonfixed Medical Treatment Facilities

(1) Nonfixed medical treatment facilities are:

(a) Medical facilities for field service with the Marine Corps; such as, aid stations, clearing stations, and division field and force evacuation hospitals.

(b) Medical facilities afloat (hospital ships, sick bays aboard ship).

(c) The medical advance base component contained within mobile type units; such as, construction battalions, cargo handling battalions, etc.

(2) *Designated Bed Capacity.*—The bed capacity of land-based, nonfixed, medical treatment facilities providing bed care, and of medical treatment facilities afloat, is referred to as the designated bed capacity, defined as follows: the number of patients' beds which is specified in a table of organization and equipment, advanced base catalog, or ship's specifications to be the number of beds a stated type of medical treatment facility is designed to provide. Whenever these basic capabilities of a medical treatment facility have been modified by competent higher headquarters so that the bed capacity of the facility is either augmented or diminished, the modified capacity thereupon becomes the designated bed capacity.

(3) *Operating Beds* are those beds in a functioning medical treatment facility which are set up, equipped, staffed, and in all respects ready for the care of patients. (A functioning medical treatment facility is one which is partially or completely set up and ready to receive patients. A nonfunctioning facility is one which is not set up and not ready to re-

ceive patients due to such conditions as being in training, in transit, staging, or held in tactical reserve.)

(4) *Occupied Beds* are those beds currently assigned to patients.

(5) *Operating Beds Available* are those of the operating beds not currently assigned to patients.

(6) *Base Hospitals.*—Although Navy base hospitals are fundamentally different from the non-fixed type of medical treatment facilities and from medical facilities afloat as to their missions and military operational use, their wartime bed capacities are nevertheless established in the same way. Therefore, in wartime or in time of a large-scale military mobilization, the terms defined in subarticles (2) through (5) will be used in determining and reporting the bed capacities and bed status of all these types.

1-13. Battle Casualty Reporting

(1) *Battle Casualty.*—A battle casualty is any person lost to an organization because of death, wound, missing, capture, or internment provided such loss is incurred in action. "In action" characterizes the casualty status as having been the direct result of hostile action; sustained in combat and related thereto; or sustained going to or returning from a combat mission provided that the occurrence was directly related to hostile action. *However*, injuries due to the elements or self-inflicted wounds are not to be considered as sustained in action and are thereby not to be interpreted as battle casualties.

(2) *Wounded in Action.*—The term "wounded in action" will be used to describe all battle casualties, other than the individuals "killed in action", who have incurred a traumatism or injury due to external agent or cause. Thus broadly used it encompasses all kinds of wounds and other injuries incurred in action, whether there is a piercing of the body, as in a penetrating or perforating wound, or none, as in a contused wound; all fractures; burns, blast concussions; all effects of gases and like chemical warfare agents; and the effects of exposure to radioactive substances.

(3) *Died of Wounds Received in Action.*—The term "died of wounds received in action" will be used to describe all battle casualties who die of wounds or other injuries received in action, after having reached any medical treatment facility. It is essential to differentiate these from battle casualties found dead or who died before reaching a medical treatment facility (the "killed in action" group). It should be noted that reaching a medical treatment facility while still alive is the criterion.

(4) *Killed in Action.*—The term "killed in action" will be used to describe battle casualties who are killed instantly or who die of wounds or other injuries before reaching any medical treatment facility.

1-14. Administrative Terminology

(1) The following terms are defined for use in Medical Department directives, regulations, and correspondence:

(a) *Medical Department*.—The *Medical Department of the Navy* is defined in article 1-1. The shortened term "*Medical Department*" is acceptable if shown in initial capitals to distinguish it from the *medical departments* (normally not capitalized) of the ships or stations.

(b) *Bureau*.—The words "the Bureau" may be used as a short title for the Bureau of Medicine and Surgery; however, the official abbreviation BUMED is preferred as being more specific.

(c) *Activities and Facilities*.—

(1) A Medical Department activity is a command activity of the naval establishment under BUMED command. It includes all of the activities listed in Standard Navy Distribution List FH of the Catalog of Naval Shore Activities, OPNAV P09B3-105.

(2) The term "Medical Department facilities" includes the BUMED commanded and/or supported activities, plus all of the medical and dental departments ashore and afloat.

(d) "*To*" *Lines for BUMED Directives*.—Three "*To*" lines peculiar to BUMED use have been standardized for directives applicable only to ships and stations having certain categories of Medical Department personnel aboard:

(1) Ships and Stations Having Medical Department Personnel includes commands having any or all of the following categories aboard: Medical Corps, Dental Corps, Medical Service Corps, Nurse Corps, Warrant Officer (PA), Hospital Corps, dental technician, occupational field XIV, and civilian professional and technical personnel who perform health services for the Navy.

(2) Ships and Stations Having Medical Personnel applies to those activities having any or all of the following aboard: Medical Corps, Medical Service Corps, Nurse Corps, Warrant Officer (PA), Hospital Corps, and civilian professional and technical personnel who perform medical services for the Navy.

(3) Ships and Stations Having Dental Personnel covers those activities having Dental Corps personnel, Medical Service Corps personnel, and dental technician occupational field XIV members who perform dental services for the Navy.

1-15. Joint Use of Military Health and Medical Facilities and Services

(1) DoD Directive 6015.5 of 5 February 1981 is quoted for information:

Reference: (a) DoD Directive 6015.5, "Joint Utilization of Military Health and Medical Facilities and Services," December 5, 1955 (hereby canceled)

- (b) DoD Instruction 6015.17, "Technical Procedures and Criteria for Planning and Acquisition of Military Health and Medical Facilities," September 24, 1968
- (c) DoD Directive 6010.4, "Dependents' Medical Care," April 25, 1962
- (d) DoD Directive 5154.6, "Armed Services Medical Regulating Office," November 26, 1974
- (e) Deputy Secretary of Defense Memorandum, "Executive Agent for all DoD Veterinary Activities," October 16, 1980 (hereby canceled)

A. REISSUANCE AND PURPOSE

This Directive reissues reference (a) and prescribes DoD policy and procedures concerning optimum joint use of military health and medical facilities and services. References (b) through (d) are related background documents.

B. APPLICABILITY

The provisions of this Directive apply to the Office of the Secretary of Defense and the Military Departments. The term "Military Services," as used herein, means Army, Navy, Air Force, and Marine Corps.

C. POLICY

The Department of Defense shall plan for and practice joint use of military health and medical facilities and services to attain the most efficient and economical operation of the Military Departments.

D. PROCEDURES AND RESPONSIBILITIES

1. *Health and Medical Personnel*. Joint use of specially trained personnel shall be practiced to obtain efficiency and economy in the operation of health and medical facilities and services. In addition, Medical and Dental Corps Reserve personnel shall be used, regardless of Military Department affiliation, on examining teams established to conduct physical examination at reserve units.

2. Use of Existing Health and Medical Facilities

a. To accomplish optimum use of existing health and medical facilities and services, every effort shall be made to reduce, consolidate, or eliminate facilities in specific areas when another facility is available to provide the necessary support. Established military medical facilities shall be made available to medical components of Reserve units in connection with training programs.

b. Beneficiaries will not be denied equal opportunity for care at a facility because the facility concerned is that of a Military Service other than that of a member or the beneficiary's sponsor.

3. *Operating Beds and Staffing Requirements*. Operational requirements of Military Services' health and medical facilities shall be based on workload experience, estimated workload, missions, and plans for optimum joint use. Significant change (expansion, curtailment, or elimination) in a jointly used health or medical service in a facility or an area shall be coordinated with the other Military Departments and reported to the Assistant Secretary of Defense (Health Affairs) before final action is taken.

4. *Dental Care*. Optimum joint use shall be made of dental facilities and services including inpatient and outpatient treatment. Hospitalized personnel shall be given authorized inpatient dental treatment. Personnel of one Military Service assigned to duty with another Service shall be given outpatient treatment. Small units or detachments, located where dental facilities of their own Service are not readily available or are uneconomical to establish, shall be

provided dental care by nearby dental facilities of other Services. Isolated individuals and groups of military personnel shall obtain dental care from civilian dentists, as authorized by the individual Military Department, when such procedures are more economical and efficient than sending patients long distances to military dental facilities or requesting mobile dental units.

5. *Veterinary Services.* The Secretary of the Army, as Executive Agent of the DoD Veterinary Services, shall effect uniform use of veterinary services throughout the Department of Defense. The Department of the Army's Veterinary Services shall be used by all Military Departments and shall include:

a. Control of animal diseases communicable to man.

b. Veterinary care for government-owned animals supported by appropriated funds.

c. Provision of military veterinarians for research and development, when required by the Military Departments.

6. *Health and Medical Education and Training.* Information regarding organized training programs, including symposia and formal postgraduate courses, shall be freely exchanged and disseminated among the Military Departments. Continuing study shall be made of military health and medical training methods and programs to standardize courses and further joint use.

7. *Preventive Medicine.* Continuing studies shall be conducted on preventive health and medical policies, organizations procedures, and publications to further standardization and joint use.

a. Preventive medicine shall include the following:

(1) Inspection of food products and sanitary inspection of establishments supplying food products to DoD Components.

(2) Use of approved lists of food supplies published by the Department of the Army.

(3) Laboratory examinations of food products.

b. Sanitary military standards for commercial food plants shall be developed by the Surgeon General, Department of the Army, for the Department of Defense.

c. The Department of the Army shall furnish to the Department of the Navy on an as required basis all services described in subparagraphs 7.a.(1) through 7.a.(3).

8. *Medical Laboratory Services.* Joint use shall be made of military hospital and other medical laboratories for the performance of clinical laboratory procedures, the examination of meat, dairy products, and other foods, the conduct of epidemiological investigations, and occupational and environmental studies. Continuing studies shall be made of medical laboratory facilities, organizations, procedures, and functions to further standardization and joint use.

F. EFFECTIVE DATE AND IMPLEMENTATION

This Directive is effective immediately. Forward one copy of implementing documents to the Assistant Secretary of Defense (Health Affairs) within 120 days.

(2) Pursuant to 10 USC §686, services and supplies may be obtained from other agencies to effect the policy contained in DOD Directive 6015.5 quoted above.

Section III. GENERAL

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1-20. American National Red Cross

(1) *General.*—The American National Red Cross was reincorporated by the act of Congress of 5 January 1905 as amended (36 USC 1 et seq.) as the agency of the Government for the fulfillment of certain treaty obligations into which the United States entered when it became signatory to the treaty of the Red Cross, or the treaty of Geneva of 22 August 1864. The number of National Red Cross societies officially recognized by the International Red Cross Committee is 63, including the American National Red Cross. The International Red Cross Committee is entrusted with the maintenance of fundamental Red Cross principles, and its essential characteristic is its absolute neutrality under the Geneva Conventions. Under these conventions the national societies are recognized by their governments as auxiliaries to the medical departments of their fighting services. They are pledged to prepare themselves in peacetime for necessary wartime work.

(2) *Welfare Program.*—Pursuant to the request of the Secretary of the Navy, the American National Red Cross, in times of peace, conducts a welfare program for members of the Navy and their dependents, including home service by local chapters, and hospital and recreation services for patients in establishments under the command of BUMED. In times of war the Secretary of the Navy may request that these programs be expanded or new services appropriate to the functions of the American National Red Cross be provided.

(3) *Representatives.*—American National Red Cross representatives assigned to naval establishments are considered to be members of the staff of the establishment for organizational purposes. The American National Red Cross will designate the representative who, acting under the commanding officer is responsible for coordinating all Red Cross activities of the establishment.

(4) *Volunteer Aid.*—In conformity with U.S. Navy Regulations, volunteer aid for Medical Department establishments shall be accepted only through the agency of the American National Red Cross. The foregoing, however, does not prohibit individuals and representatives of other organizations from visiting Medical Department establishments or, when ap-

proved by the commanding officer, acceptance by patients of personal gifts or services tendered by individuals.

(5) *Requests for Services.*—Requests for Red Cross services in new establishments, and matters relating to the functioning of Red Cross representatives within an establishment or affecting general policy which are not provided for in current instructions, shall be referred to BUMED for appropriate action.

1-21. Geneva Conventions

(1) Officers of the Medical Department shall familiarize themselves with the Geneva Conventions. The Conventions are contained in the Annex to Naval Warfare Information Publication 10-2, Law of Naval Warfare, which is available to all ships and stations.

1-22. Off-duty Remunerative Professional Employment (Regulatory)

(1) *General.*—Off-duty remunerative professional civilian employment, including self-employment (hereto referred to as off-duty employment) of active duty Medical Department officers is subject to policies herein stated by the Chief, Bureau of Medicine and Surgery, and policies applicable to all members of the naval service as stated by the Secretary of the Navy (SECNAVINST 5370.2 series) and the Commander, Naval Military Personnel Command (MIL PERSMAN 3420500). No Medical Department officers on active duty shall engage in any off-duty employment without first obtaining the permission of the commanding officer.

(2) *Guidelines.*—

(a) Medical Department officers on active duty are in a 24-hour duty status and their military duty takes precedence on their time, talents, and attention.

(b) Permission for an officer to engage in off-duty employment shall be based on a determination by the commanding officer that the permission requested is consistent with these guidelines and that the proposed employment will not interfere with the officer's military duties. If approved, employment will normally not exceed 16 hours per week. Periods in excess of 16 hours per week can be authorized

only if the commanding officer finds that special circumstances exist which indicate that no conflict with military duties will occur, notwithstanding the additional hours. Permission to engage in off-duty employment may be withdrawn at any time.

(c) A Medical Department officer in off-duty employment shall not assume primary responsibility for the care of any critically ill person on a continuing basis as this will inevitably result in compromise of responsibilities to the patient, or the primacy of military obligations.

(d) Medical Department officer trainees are prohibited from off-duty employment. Other Medical Department officers are discouraged from off-duty employment. No officer shall request or be granted administrative absence for the primary purpose of conducting off-duty employment.

(e) Off-duty employment shall not be conducted on military premises, involve expense to the Federal government, nor involve use of military equipment, personnel, or supplies. Military personnel may not be employed by Medical Department officers involved in off-duty employment.

(f) Off-duty employment shall not interfere, nor be in competition, with local civilian practitioners in the health professions and must be carried out in compliance with all applicable licensing requirements. To ensure this, a statement shall be provided from the appropriate local professional association indicating that there is a need for the individual's service in the community. Local licensing requirements are the responsibility of officers wishing to engage in private practice. Those engaging in private practice are subject to all requirements of the Federal narcotic law, including registration and payment of tax.

(g) There may be no self referral from the military setting to their off-duty employment on the part of military Medical Department officers.

(h) No Medical Department officer on active duty in off-duty employment may solicit or accept a fee directly or indirectly for the care of a member, retired member, or dependent of such members of the uniformed services as are entitled to medical or dental care by those services. "Indirect acceptance" shall be interpreted to include those fees collected by an emergency room or walk-in clinic staffed by a military medical officer. Entitled members must be screened and identified as such by the facility and their charges *reduced* to reflect that portion of the charges which are accounted for by the military medical officer's services. Nor may such a fee be accepted directly or indirectly for the care of Veterans Administration beneficiaries.

(i) The Assistant Secretary of Defense (Health Affairs) has decreed that it will be presumed that a conflict of interest exists and, hence, CHAMPUS payments will be disallowed in any claim of a CHAMPUS provider who employs an active duty

military member or civilian employee. The only two exceptions are:

(1) Indirect payments to private organizations to which physicians of the National Health Service Corps (NHSC) are assigned (but direct payments to the NHSC physician would still be prohibited).

(2) Payments to a hospital employing Government medical personnel in an emergency room provided the medical care was not furnished directly by the Government personnel.

(j) Subsidiary obligations arising out of off-duty employment, such as appearances in court or testimony before a compensation board, which take place during normal working hours, shall be accomplished only while on annual leave.

(k) These guidelines do not apply to the provision of emergency medical assistance in isolated instances. Also excluded are nonremunerative community services operated by nonprofit organizations for the benefit of all the community and deprived persons, such as a drug abuse program, program volunteer, VD centers, and family planning centers.

(l) Medical Department officers are expected to be aware of and comply with all other statutes and regulations pertaining to off-duty employment. Where doubt exists as to whether all applicable constraints have been considered, consultation should be effected with the local naval legal service office.

(3) The local command has primary responsibility for control of off-duty employment by Medical Department officers. Guidelines above serve as a basis for carrying out this responsibility.

(4) Medical Department officers requesting permission to engage in off-duty employment shall submit their request to the commanding officer on NAVMED 1610/1, Off-duty Remunerative Professional Civilian Employment Request, and shall sign the "Statement of Affirmation" thereon in the commanding officer's presence. Approval or disapproval by the commanding officer shall be indicated in the appropriate section of NAVMED 1610/1. Approval must be renewed every 6 months.

(5) The requester shall inform the commanding officer in writing of any deviation in the stated request prior to the inception of any such changes.

(6) Permission shall be withdrawn at any time by the commanding officer when such employment is determined to be inconsistent with the above guidelines. Where permission is withdrawn, the officer affected shall be afforded an opportunity to submit to the commanding officer a written statement containing the Medical Department officer's views or any information pertinent to the discontinuance of the employment.

(7) Reports are not required to be submitted to BUMED by field activities. However, during Medical and Dental Inspectors General visits or other administrative on-site visits local command compliance

with this article will be reviewed. In addition, adequate records should be maintained to provide summarized information as may be necessary for monitoring and evaluating the functioning of this program by BUMED or higher authority.

1-23. Witness in Court (Regulatory)

(1) *Appearance.*—A Medical Department officer who appears in court as an expert witness in litigation arising out of private practice shall so appear out of uniform, if possible, and shall establish carefully the character of both the officer's appearance and testimony as being other than on behalf of the Navy.

(2) *Fees.*—

(a) A Medical Department officer appearing as a witness during "off-duty" hours for a party not eligible for medical care in military facilities may retain any fee within the Standards of Conduct prescribed by Department of Defense Directives.

(b) A Medical Department officer who appears privately and voluntarily as a witness on behalf of a member or other person generally eligible for care in naval medical facilities shall not accept a fee, directly or indirectly, except for actual transportation costs.

(c) In instances where the interest of the Government is not involved, a Medical Department officer who appears involuntarily as the physician or dentist having firsthand knowledge of a person eligible for care in a naval medical or dental facility may accept any fee established by rule or statute and one who appears as an expert may accept any negotiated higher expert witness fee commensurate with professional local custom; however, such fee, beyond any actual expenses, shall be delivered to the disbursing officer of the command for deposit to the Miscellaneous Receipt Account 173099, recoveries and refunds, not otherwise classified.

(d) Where a Medical Department officer appears as a witness on behalf of the Government under Temporary Additional Duty Orders, the officer is compensated in accordance with Navy Travel Instructions, par. 6200 in conjunction with chapter 4, part B; see also NAVCOMPT Manual, par. 046278-1. The officer will not otherwise request or accept a witness fee. The foregoing applies in such instances as where a Government third party claim is attached to an independent suit filed by a member or other person eligible for care in a naval medical facility, the Government is a coclaimant at suit, or the Government is being sued under the Federal Tort Claims Act and the Medical Department officer is appearing as having firsthand knowledge of the facts or as an expert witness.

1-24. Civil Actions

(1) *Report.*—If a Medical Department officer is apprised of any civil litigation or legal proceedings be-

ing brought against the officer wherein the United States is in legal effect the defendant, the officer shall immediately advise the commanding officer so that a report can be made as set forth in the Manual of the Judge Advocate General. A copy of the report shall be submitted to BUMED.

(2) *Insurance.*—The Navy Department does not recommend either for or against insurance of individuals by commercial insurers against negligence which may occur in line of duty or scope of employment. The provisions of 10 U.S.C. § 1089(a)–(f) are quoted herein for information:

§ 1089. Defense of certain suits arising out of medical malpractice

(a) The remedy against the United States provided by sections 1346 (b) and 2672 of title 28 for damages for personal injury, including death, caused by the negligent or wrongful act or omission of any physician, dentist, nurse, pharmacist, or paramedical or other supporting personnel (including medical and dental technicians, nursing assistants, and therapists) of the armed forces, the Department of Defense, or the Central Intelligence Agency in the performance of medical, dental, or related health care functions (including clinical studies and investigations) while acting within the scope of his duties or employment therein or therefor shall hereafter be exclusive of any other civil action or proceeding by reason of the same subject matter against such physician, dentist, nurse, pharmacist, or paramedical or other supporting personnel (or the estate of such person) whose act or omission gave rise to such action or proceeding.

(b) The Attorney General shall defend any civil action or proceeding brought in any court against any person referred to in subsection (a) of this section (or the estate of such person) for any such injury. Any such person against whom such civil action or proceeding is brought shall deliver within such time after date of service or knowledge of service as determined by the Attorney General, all process served upon such person or as attested true copy thereof to such person's immediate superior or to whomever was designated by the head of the agency concerned to receive such papers and such person shall promptly furnish copies of the pleading and process therein to the United States attorney for the district embracing the place wherein the action or proceeding is brought, to the Attorney General and to the head of the agency concerned.

(c) Upon a certification by the Attorney General that any person described in subsection (a) was acting in the scope of such person's duties or employment at the time of the incident out of which the suit arose, any such civil action or proceeding commenced in a State court shall be removed without bond at any time before trial by the Attorney General to the district court of the United States of the district and division embracing the place wherein it is pending and the proceeding deemed a tort action brought against the United States under the provisions of title 28 and all references thereto. Should a United States district court determine on a hearing on a motion to remand held before a trial on the

merits that the case so removed is one in which a remedy by suit within the meaning of subsection (a) of this section is not available against the United States, the case shall be remanded to the State court.

(d) The Attorney General may compromise or settle any claim asserted in such civil action or proceeding in the manner provided in section 2677 of title 28, and with the same effect.

(e) For purposes of this section, the provisions of section 2680(h) of title 28 shall not apply to any cause of action arising out of a negligent or wrongful act or omission in the performance of medical, dental, or related health care functions (including clinical studies and investigations).

(f) The head of the agency concerned or his designee may, to the extent that he or his designee deems appropriate, hold harmless or provide liability insurance for any person described in subsection (a) for damages for personal injury, including death, caused by such person's negligent or wrongful act or omission in the performance of medical, dental, or related health care functions (including clinical studies and investigations) while acting within the scope of such person's duties if such person is assigned to a foreign country or detailed for service with other than a Federal department, agency, or instrumentality or if the circumstances are such as are likely to preclude the remedies of third persons against the United States described in section 1346(b) of title 28, for such damage or injury.

(3) *Witness in Court.*—See article 1-23.

(4) *Ambulances.*—Navy ambulances and Navy ambulance drivers are susceptible to efforts or requests by local police officers or other persons for aid in cases of accidents or emergencies. Operators of ambulances, either members of the Hospital Corps or civil employees, should be thoroughly indoctrinated:

(a) To adhere strictly to orders for picking up and transporting the patient for whom dispatched.

(b) To remain with vehicle and never to stop or to leave ambulance out of curiosity when halted by traffic conditions at the scene of an accident when the driver by reason of orders to pick up and carry a Navy patient is not in a position to offer a patient care or ambulance service.

(c) To recognize that the Medical Department is expected as a matter of policy to cooperate with local authorities in emergencies when this cooperation will not interfere with a Medical Department operation, and that operators of Navy ambulances which are not carrying patients or proceeding under orders to pick up patients are expected to offer, in humanitarian emergency situations, such assistance as they are qualified to render.

(d) In any instance in which an ambulance carrying a patient or proceeding under orders to pick up a patient is stopped or otherwise subjected to interference by State or other local authorities for any reason whatever, including aid to an emergency humanitarian patient: to give courteous information about current orders; to courteously request that compliance with these orders not be subjected to interference; and to report to the commanding officer, for transmittal by the commanding officer to the Judge Advocate General of the Navy, and measures applied by State or local authorities which prevent direct compliance with orders.

1-25. Restrictions Relative to Prospective Applicants (Regulatory)

(1) Officers of the Medical or Dental Corps on active duty shall not undertake to operate upon or treat prospective applicants for the Navy or Marine Corps, Regular or Reserve, with a view to correcting defects, disqualifications, and disabilities barring them from enlistment or appointment.

Chapter 2

MEDICAL CORPS

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Section I. ESTABLISHMENT

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2-1. Establishing Legislation

(1) The Medical Corps was the first corps to have duties relating to medical and sanitary matters for the Navy. The subsequent establishment of other corps with related medical duties indicated that the Medical Corps was a part of the Medical Department as described in 10 U.S.C. 6-27 and article 1-1.

2-2. Mission

(1) The mission of the Medical Corps is to safeguard and promote the health of Navy and Marine

Corps and other Federal uniformed services personnel. This includes medical care and treatment of sick and injured active duty personnel and their dependents and retired members and their dependents; training programs for Medical Department personnel; continuing programs of medical research; prevention and control of diseases and injuries; promotion of physical fitness; medical care for on-the-job injuries and illnesses of Federal civilian employees and others as authorized by law.

Section II. ORGANIZATION

Medical Corps Division of BUMED	Article 2-3
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2-3. Medical Corps Division of BUMED

(1) The Medical Corps Division of BUMED is responsible to the Assistant Chief for Professional Development for the programs and policies established for the Medical Corps.

(2) The Division has a Director and Deputy Director who provide the management and direction of all functions of the Division. The Director develops and implements policy; provides liaison with NAVMILPERSCOM; and monitors recruitment, training, and retention of Medical Corps officers.

(3) The Division is comprised of the following branches whose responsibilities are described:

(a) The Program and Analysis Branch provides staff assistance on administrative policies and

procedures; monitors personnel policies impacting on the Medical Corps; develops a force structure which is responsive to changing requirements; and accomplishes Medical Corps special studies.

(b) The Human Resource Inventory and Accounting Branch prepares correspondence and personnel actions; develops budgets and cost projections for VIP and COPAY; develops Medical Corps strength and promotion plans; and accomplishes personnel actions.

(c) The Procurement Programs and Accessions Branch establishes liaison with the Navy Recruiting Command; and administers selected accessions programs.

Section III. MEDICAL CORPS OFFICERS

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2-4. Grades and Strength

(1) Title 10 U.S.C. 5404 provides that the total authorized number of commissioned officers of the Medical Corps shall be sixty-five one-hundredths of one per centum of the sum of the total authorized number of commissioned officers of the Navy and Marine Corps (exclusive of commissioned warrant officers), the total authorized number of enlisted personnel of the Navy and Marine Corps, the total authorized number of midshipmen at the Naval Academy, the actual number of commissioned warrant officers and warrant officers on the active list of the Navy and Marine Corps, and the actual number of midshipmen on active duty for flight training. The Act further requires that the Secretary of the Navy shall make computations to determine the authorized strength of the Medical Corps as of January 1 of each year and the number of officers so determined shall be considered the authorized number of officers for the corps until a subsequent computation is made for the next year. This authorized strength of the Medical Corps represents a maximum strength. The number actually on the active list and on active duty varies from year to year in accordance with the allocation of funds available in the annual appropriations acts for the Navy. This number on an annual basis constitutes the "appropriated strength."

(2) Officers of the Medical Corps shall be distributed in various grades in that corps but the number of rear admirals in the Medical Corps shall not exceed five-tenths of one per centum of the officers in that corps serving on active duty at any one time. Further, except in time of war or national emergency, the number of rear admirals in the Medical Corps on active duty may not exceed 15.

2-5. Appointments

(1) *Applications.*—Applications for appointment in the Medical Corps of the Regular Navy or the Naval Reserve from civilian physicians or members of the Inactive Reserve are submitted to the Navy Recruiting Command in accordance with current instructions.

(2) *Original Appointments.*—Under 10 U.S.C. 5574, original appointments to the active list of the

Navy Medical Corps may be made from persons who are at least 21 and under 32 years of age who have been examined and found qualified by a board of Medical Corps officers convened by the Secretary of the Navy. Further, the Secretary of the Navy may prescribe regulations for appointments from among doctors of medicine and doctors of osteopathy.

(3) *Temporary Appointments.*—Under 10 U.S.C. 5599, only the President is authorized to make appointments for temporary service in the Medical Corps.

2-6. Promotions

(1) *Eligibility.*—An officer in the Medical Corps shall become eligible for consideration by a selection board for promotion to the next higher grade when the medical officer's running mate of the line becomes eligible for such selection, except that an officer in the grade of lieutenant (junior grade) or lieutenant shall not be eligible for such selection unless the medical officer is in the promotion zone in such grade or is senior to officers in the promotion zone in the grade in which the medical officer is serving.

(2) *Examinations Required.*—To be eligible for promotion, medical officers must pass such professional, moral, mental, and physical examinations that the Secretary of the Navy may prescribe. Failure to pass the physical examination shall not exclude from promotion any medical officer:

(a) Who would otherwise be entitled to such promotion.

(b) Whom a board of medical examiners may find not physically qualified for duties at sea as a result of wounds received in the line of duty.

(c) Whose physical disqualifications do not incapacitate the officer for other duties in the grade for which the officer is being considered for promotion.

(3) *Professional Examinations.*—When professional examinations for advancement in grade are prescribed by the Secretary of the Navy, the nature and scope of such examinations will be in accordance with current directives.

Section IV. DUTIES OF THE MEDICAL CORPS OFFICER

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2-7. Duty Assignments

(1) Medical Corps officers may be assigned to: shore establishments, training duties, or operational duties in aerospace, undersea, surface, or Fleet Marine Force.

2-8. General Responsibilities (Regulatory)

(1) All officers of the Medical Corps are charged with responsibility for the treatment of sick and injured personnel, and for prevention and control of disease.

(2) In addition, the medical officer will be responsible, under the commanding officer, for maintaining the health of the personnel of the command, making inspections incident thereto, and advising the commanding officer with respect to hygiene, sanitation, safety, and environmental conditions effecting the command.

(3) The head of a medical department of a command or other activity will direct, administer, and supervise the services of subordinates requiring of them a proper and efficient performance of their duties.

2-9. Care of the Sick and Injured (Regulatory)

(1) The medical officer will provide for the sick and injured the most careful professional attention and care consistent with the highest standards of modern medical practice. Arrangements will be made for the proper messing of patients, the proper stowage and safeguarding of patients' effects, and attentiveness to the patients' well-being at all times.

(2) The medical officer will be responsible for the overall supervision of the treatment of patients and require of all members

of the medical department strict compliance with orders that are written for patients. The medical officer will require that no deviation is made from orders given by the medical officer in charge of a patient except in emergency, or by order of higher authority, or by order of another officer of the Medical Corps having temporary charge of the patient.

(3) The medical officer will require that daily reports of the sick be submitted following articles 23-51 and 23-52.

(4) In complicated situations, the medical officer will consult with other Navy Medical Corps officers and provide information concerning diagnosis, treatment, and patient management.

2-10. Health Standards (Regulatory)

(1) The responsibility of the medical officer in matters of health extends into fields under the cognizance of other departments. Nutritional adequacy; food handling and food preparation; environmental controls; housing; insect, pest, and rodent control; water supply; and waste disposal all have a direct bearing on the health of naval personnel. The medical officer, because of special qualifications, must assume the initiative in maintaining health standards in these spheres. The medical officer must assure adequate provision, including spaces, for the care of the sick. The medical officer's responsibility in preventive medicine is discussed in chapter 22.

(2) The medical officer will recommend to the commanding officer that drugs, devices, and other medical items not be sold in Navy or Marine Corps exchanges or ship's stores when considered to be medically susceptible to inappropriate use.

2-11. Physical Fitness of Personnel (Regulatory)

(1) The medical officer will make appropriate recommendations to the proper authority for the promotion of health and the physical fitness of personnel. The physical and mental benefits derived from athletics, recreation, and other measures to improve or maintain a satisfactory state of physical fitness should be emphasized.

(2) The medical officer will, with the approval of the commanding officer, conduct or direct examinations of personnel of the command whenever there is reason to believe that diseases are being concealed. During such examinations the physical condition and personal hygiene of personnel will be observed.

2-12. Directives (Regulatory)

(1) The medical officer, subject to the orders of the commanding officer, will prepare and maintain the necessary directives for the organization and operation of the medical department.

2-13. Medical Journal (Regulatory)

(1) Each medical activity or facility will maintain a journal containing a complete, concise, chronological record of events concerning the Medical Department (other than medical histories of individuals), which may be of importance or historical value.

2-14. Reports to the Officer of the Deck or Day (Regulatory)

(1) Injuries or death of personnel, damage, destruction or loss of Medical Department property, and any important occurrence will be reported by the medical officer to the officer of the deck or other proper official for entry in the log or journal of the command or activity.

(2) Patients in a serious or very serious condition will be the subject of a report to the commanding officer or officer of the deck or day, together with the necessary information for the notification of next of kin.

2-15. Educational Measures (Regulatory)

(1) The medical officer, with the approval of the appropriate authority, will conduct health education programs, including the dissemination of information regarding the prevention of diseases and other subjects pertaining to hygiene and sanitation.

(2) The medical officer will supervise the instruction of personnel regarding venereal diseases, and advise them of the

associated dangers. Information distributed by COMNAVMEDCOM relative to social hygiene will be used.

(3) The medical officer, with the approval of the appropriate authority, will conduct a program of first aid instruction for officers and enlisted personnel attached to the command which will ensure knowledge and ability in the principles of first aid.

(4) The medical officer will provide for the instruction of hospital corpsmen as set forth in the Hospital Corps chapter.

(5) The medical officer will make provisions for the indoctrination of personnel under the medical officer's charge in Navy and Medical Department regulations and administrative procedures.

2-16. Preparation for Emergency (Regulatory)

(1) The medical officer will ensure that the medical department is at all times prepared to meet medical emergencies.

2-17. Cooperation With Other Agencies (Regulatory)

(1) The medical officer will cooperate with the Public Health Service and other Federal, State, and local agencies for the collection of vital statistics, and for the prevention of disease and the reporting of communicable diseases following articles 22-17 through 22-21.

(2) The regional health directors in each of the Public Health Service regional areas will cooperate with naval authorities for the purpose of safeguarding the health of military personnel in extramilitary areas and may, if desired, act as the liaison between the naval activity and the State or local health agencies to solve community health problems of interest to the Medical Department of the Navy.

2-18. Compulsory Medical or Surgical Treatment (Regulatory)

(1) By authority delegated by the Secretary of the Navy, and with the approval of the commanding officer, the senior medical or dental officer, as appropriate, of a ship or station, after consultation with other medical or dental officers if available, will, where in the medical officer's judgment the best interests of the individual or of the service require, take the following measures with or without the consent of the individual concerned:

(a) Emergency care required to preserve the life or health of the member.

(b) Care necessary to protect the life or health of a member who is considered by a psychiatrist to be mentally incompetent.

(c) Routine treatment for minor or temporary disabilities in time of war or in peacetime when the mission of the activity concerned would be severely hindered by failure to provide treatment.

(d) Isolation and quarantine in instances of suspected or proved communicable disease where medically indicated or required by law.

(e) Detention on closed wards where necessary to ensure proper treatment or to protect the member or others from harmful acts.

(2) Reference should be made to article 18-15 for guidance concerning the disposition of naval personnel who refuse medical, surgical, dental, or related diagnostic measures.

2-19. Medical Care of Civilians (Regulatory)

(1) The commanding officer or senior officer present may require officers of the Medical Department to provide care to persons not in the naval service when such aid is necessary and humanitarian, or when principles of international courtesy may be applicable.

(2) The services for civilian employees and other persons eligible for care at naval medical treatment facilities are given in chapter 15 and NAVMEDCOMINST 6320.3 series.

2-20. Dental Treatment (Regulatory)

(1) Except in an emergency, the medical officer of a command or activity having no officer of the Dental Corps attached will make an appointment in advance when it becomes necessary to send patients elsewhere for dental services.

(2) When the medical officer sends a patient to another command or activity for dental services, the medical officer will make the patient's Dental Record available to the dental officer of such command or activity. After the necessary entries have been made, the dental officer will return the Dental Record to the person having custody of the Health Record.

(3) The medical officer will notify the dental officer whenever a person suffering from syphilis or any other disease in a communicable stage is sent for dental treatment.

(4) When officers or enlisted personnel are ordered to a command or activity where the services of an officer of the Dental Corps are not available, the medical officer will refer such persons to an officer of the Dental Corps for examination and treatment prior to their departure.

(5) The medical officer will be guided by the recommendations of the dental officer concerning discharge or granting of liberty to dental patients on the sicklist.

(6) When the Health Record of an individual has been lost, the medical

officer may request the dental officer to prepare a new Dental Record.

(7) The medical officer of a command or activity having a dental department will send to the dental department the Dental Records of officers and enlisted personnel who arrive for duty or training.

(8) The medical officer, or other person who has custody of the Health Record, will be responsible for the inclusion of a current Dental Record when the Health Record is transferred.

(9) When officers of the Medical Corps record dental examinations on Dental Records or other forms, in the absence of officers of the Dental Corps they will be guided by the instructions concerning the Dental Record in chapter 6, section XV. When recording dental examinations on Standard Form 88, they will be guided by instructions in chapter 15.

2-21. Medical Intelligence (Regulatory)

(1) The medical officer of a command or activity, particularly if in a foreign port, will cooperate with the U.S. intelligence officers and furnish them such data as may be required from a medical standpoint.

(2) When at foreign stations or when cruising in waters outside of the United States, medical officers will contact U.S. naval attaches in foreign countries and Naval Intelligence Command officers in U.S. territories in advance for briefing with regard to medically-relevant intelligence in the area or areas to be visited.

2-22. Offices of Medical Affairs (Regulatory)

(1) With CNO's disestablishment of the offices of the commandants of naval districts (except NAVDIST WASH, DC), the Naval Medical Command designated certain of its medical facilities and NAVDIST WASH, DC to assume responsibilities formerly under the cognizance of district medical officers. These designated activities are referred to as offices of medical affairs (OMA).

(2) Each OMA is responsible for continued administration of:

(a) The nonnaval medical care program.

(b) The decedent affairs program.

(c) Medical cognizance of the sick and injured.

(d) Other medical administrative matters as assigned by COMNAVMEDCOM and delineated in NAVMEDCOMINST 6010.3.

(3) NAVMEDCOMINST 6320.1 series delineates the OMAs and their areas of responsibility.

Section V. PHYSICIAN'S ASSISTANT

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2-23. Establishing Legislation

(1) The Physician's Assistant (PA) Program of the Navy was originated to alleviate the shortage of physicians by the extension of health care delivery services. The Physician's Assistant (PA) warrant is described in 10 USC 5596(d).

2-24. Mission

(1) The fundamental objective of the PA is to extend the delivery of quality primary health care to more patients under the supervision of medical officers. The PA is not a physician surrogate.

2-25. Procurement

(1) PA's are procured from two sources. The civilian community and advanced hospital Corps personnel who are graduates of advanced hospital Corps technician or nuclear submarine medicine technician schools.

2-26. Appointments

(1) Upon completion of a formal course of instruction accredited by the American Medical Association and eligibility to take the National Certification exam, original appointments shall be as warrant officers of the Navy (WO2). All male inservice PA selectees are tendered a temporary warrant appointment. All other male and female selectees are given a permanent warrant appointment in accordance with 10 USC 555(b).

(2) Male warrant officers not previously appointed permanent status may apply for permanent status after completion of 3 years warrant service.

2-27. Promotion

(1) Warrant PA's shall become eligible for consideration by a selection board for promotion to the next highest grade when they have completed the required minimum time in grade and have been found physically, morally, and professionally qualified for promotion.

(2) The in zone promotion opportunity to Warrant Officer W-3 and W-4 is not less than 80 percent of all Navy warrant officers in the zone.

2-28. Program Strength

(1) The number of appointments to this program will be independent of appointments made under separate regulations governing the Regular Navy Warrant Officer Program. Warrant Officer Physician's Assistant billets will be provided from existing officer billets subject to the concurrence of the cognizant human resources claimant or as the Chief, Bureau of Medicine and Surgery makes provision for the fiscal process. Program strength will be established by the Commander, Naval Military Personnel Command upon recommendations made by the Chief, Bureau of Medicine and Surgery.

2-29. Utilization

(1) The policy guidelines concerning utilization of Navy physician's assistants are contained in BU MEDINST 6550.5 series.

Chapter 6

DENTAL CORPS

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Section I. ESTABLISHMENT

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6-1. Establishing Legislation

(1) The Navy Dental Corps was established by provisions of an act of 22 August 1912 (now codified by act approved 10 Aug. 1956, 10 U.S.C. 6027). This act authorized the appointment of not more than 30 assistant dental surgeons to serve professionally the personnel of the naval service and to perform such other duties as may be prescribed by competent authority.

6-2. Mission

(1) The primary function of the Navy Dental Corps is to provide such care for active duty Navy and Marine Corps personnel as will prevent or remedy diseases, disabilities, and injuries of the teeth, jaws, and related structures, which may directly or indirectly interfere with the performance of military duties.



Section II. ORGANIZATION

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6-3. Chief of the Dental Corps

(1) The Chief of the Dental Corps also acts as the Assistant Chief for Dentistry and the Chief of the Dental Division of BUMED.

6-4. Dental Division of BUMED

(1) *Establishment.*—The Secretary of the Navy, on 28 June 1946, established the Dental Division within the Bureau of Medicine and Surgery, in accordance with the act approved 28 December 1945 (10 U.S.C. 5138).

(2) *Responsibility.*—All matters relating to dentistry are required by law to be referred to the Dental Division and that division is responsible for the study, planning, and direction of all matters coming within

its cognizance. Specifically, the Dental Division is required to:

(a) Establish professional standards and policies for dental practice.

(b) Conduct inspections and visits for maintenance of such standards.

(c) Initiate and recommend action pertaining to complements, appointments, advancement, and training of dental personnel.

(d) Serve as the advisory agency for BUMED on all matters relating directly to dentistry.

(3) *Organization.*—The Dental Division of BUMED is organized as shown in the organization chart on the next page. Responsibilities of branches and special positions of the Dental Division are set forth in the following articles.

ORGANIZATION CHART OF
DENTAL DIVISION TO BE
PUBLISHED

6-5. Chief of the Dental Division

(1) The Assistant Chief for Dentistry and Chief of the Dental Division, Bureau of Medicine and Surgery, is responsible to the Chief of the Bureau for the supervision, direction, and coordination of the Navy Dental Corps and all associated programs. This Dental Corps Flag Officer is responsible for continual appraisal of all programs over which cognizance has been assigned and coordinates dental matters with other Assistant Chiefs of the Bureau of Medicine and Surgery.

(2) The Chief of the Dental Division is responsible for the performance of all the functions of the Dental Division and is detailed from among the officers of the Dental Corps in the grade of rear admiral, in accordance with 10 U.S.C. 5138.

(3) The Chief of the Dental Division, while so serving, receives the pay and allowances provided by law for rear admirals of the upper half and is entitled, in all respects, to the same privileges of retirement and retired pay benefits as are provided by law in 10 U.S.C. 5133 and 5138.

(4) The Chief of the Dental Division is assisted by the staff of the Dental Division in carrying out these responsibilities.

(5) The Chief of the Dental Division coordinates dental matters between the Dental Division and the Assistant Chief for Professional Development.

6-6. Deputy Chief of the Dental Division

(1) The Deputy Chief of the Dental Division is the nonflag dental officer next in authority to the Chief of the Dental Division and is responsible for the projection of the policies of the Chief of the Dental Division. In the absence of the Chief of the Dental Division and the Inspector General, Dental, the Deputy Chief acts for them. The Deputy Chief is responsible for the internal management of the Dental Division.

6-7. Professional Branch

(1) This Branch advises the Chief of the Dental Division on professional standards and practices,

training programs, preventive dentistry programs, hospital dentistry, and dental technician programs and conducts liaison with other offices as may be appropriate.

6-8. Dental Operations Branch

(1) This Branch advises the Chief of the Dental Division on matters related to dental finance, materiel, logistics, organization, and dental facility planning and statistics.

6-9. Personnel Branch

(1) This Branch advises the Chief of the Dental Division on the requirements, qualifications, procurement, assignment, and distribution of dental personnel.

6-10. Inspector General, Dental

(1) The Inspector General, Dental, is responsible to the Chief of the Dental Division for planning, coordinating, and conducting the inspection program of the Navy Dental Corps except for those areas of responsibility which rest with the Commandant of the Marine Corps, to assure efficiency and conformance with BUMED policies. The Inspector General, Dental advises the Chief of the Bureau via the Chief of the Dental Division regarding the results of inspections which were made or which are reported to the Inspector General, Dental.

6-11. Marine Corps—BUMED Dental Liaison Officer

(1) The Marine Corps—BUMED Dental Liaison Officer maintains liaison between the Commandant of the Marine Corps and the Assistant Chief for Dentistry on all matters relating to the dental service support for the U.S. Marine Corps.

(2) This officer's official title is: The Dental Officer, United States Marine Corps.

(3) The Dental Officer, USMC, maintains liaison with the office of The Medical Officer, USMC.

Section III. DENTAL CORPS OFFICERS

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6-14. Grades and Strength

(1) The Navy Dental Corps consists of officers in the grades of lieutenant; lieutenant commander; commander; captain; and rear admiral.

(2) The total authorized number of officers of the Dental Corps on the active list is 2/10 of 1 percent of the sum of the following:

(a) The authorized strengths of the active lists of officers of the Navy and the Marine Corps authorized by 10 U.S.C. 5403, 5404, and 5405.

(b) The authorized strengths of the Regular Navy and the Regular Marine Corps in enlisted members authorized by 10 U.S.C. 5401 and 5402.

(c) The authorized strength of the Navy in midshipmen at the Naval Academy.

(d) The actual number of officers holding permanent appointments in warrant officer grades in the Regular Navy and the Regular Marine Corps, excluding retired officers.

(e) The actual number of aviation midshipmen on active duty as appointed under 10 U.S.C. 6906 (10 U.S.C. 5404).

(3) The Secretary of the Navy computes the authorized strength of the active list of the Navy in officers in the Dental Corps as of 1 January of each year (10 U.S.C. 5404). The terms "active list of the Navy" and "active list of the Marine Corps" as used in this article mean the lists of officers of the Regular Navy and the Regular Marine Corps, other than retired officers, holding permanent appointments in grades above chief warrant officer, W-4 (10 U.S.C. 5001 (a)(9-10)).

6-15. Appointments

(1) *Appointments.*—Appointments in the Dental Corps of the U.S. Navy and the Naval Reserve are made as vacancies occur or as otherwise determined by the Commander, Naval Military Personnel Command.

(2) *Qualifications for Appointments.*—

(a) *Regular Navy.*—

(1) Sex—male or female.

(2) Citizenship—United States citizen.

(3) Age—as determined by the Secretary of the Navy depending upon grade for which eligible.

(4) The grade in which appointed will be determined by training (including internship/resi-

dency), experience as a civilian dentist, previous military service as a dental officer and other commissioned service.

(5) The applicant must be a graduate of a dental school approved by the American Dental Association and currently licensed to practice dentistry in a State, the District of Columbia, Commonwealth of Puerto Rico, or a territory of the United States.

(6) The applicant must be physically qualified in accordance with standards established by the Bureau of Medicine and Surgery and must meet certain mental, moral, and professional qualifications as determined by a board of officers appointed by the Secretary of the Navy.

(7) Additional qualifications may be promulgated by the Commander, Naval Military Personnel Command from time-to-time.

(b) *Naval Reserve (Active/Inactive).*—The qualifications for appointment are the same as above, except that the applicant must be a U.S. citizen or alien who has been lawfully admitted to the U.S. for permanent residence and holds a current Alien Registration Receipt Card (I-151).

(3) *Application for Appointment.*—

(a) *Regular Navy.*—Submit applications to the Commander, Naval Military Personnel Command in accordance with appropriate articles in BUPERSMAN.

(b) *Naval Reserve.*—Submit applications to the Commander, Navy Recruiting Command via the nearest Navy recruiting district office.

(4) *Consideration of Candidate for Appointment.*—

(a) *Regular Navy.*—Professional qualifications will be considered by a duly constituted board of dental officers appointed by the Secretary of the Navy.

(b) *Naval Reserve (Active/Inactive).*—Professional qualifications of a candidate for appointment in the Naval Reserve will be considered by dental officers meeting in the Bureau of Medicine and Surgery.

6-16. Promotions

(1) Officers of the Dental Corps become eligible for promotion when they accumulate the

required promotion and entry grade credits, or complete the prescribed period of active duty in the next lower grade as specified in Public Law 90-228 of 28 December 1967, as promulgated to the military services by DOD Directive 1320.7 series.

6-17. Retirement

(1) The several types of retirement for officers of the Regular Navy and certain officers of the Naval Reserve are explained in article 3860100 of the BUPERSMAN and current directives.

Section IV. DUTIES OF THE DENTAL CORPS OFFICER

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6-21. Duty Assignments

(1) Dental officers are assigned to duty in naval activities in the United States, to duty afloat in the large combatant and auxiliary ships of the fleet, to oversea duty, and to duty with the Marine Corps. The normal rotation pattern is an initial tour of duty in the United States, except Hawaii or Alaska, and then sea or oversea duty, including Hawaii and Alaska, followed by another tour of duty in the United States, except Hawaii or Alaska. Subsequent tours of duty will be in consonance with the overall needs of the naval service.

(2) A tour of duty is influenced by several factors. These include, but are not limited to, the ratio of sea and oversea billets to those ashore within the United States, except Hawaii and Alaska; the number of officers on active duty for limited periods; requirements for officers with special qualifications; billets of an unusually arduous nature or in isolated areas; and training requirements. The length of tour shall be in accordance with policy set forth by the Commander, Naval Military Personnel Command.

6-22. The Dental Officer/Head, Branch Dental Clinic

(1) The Secretary of the Navy shall prescribe regulations for dental services on ships and at shore stations; such services shall be accomplished by the assigned dental officer, who is responsible to the commanding officer of the ship, station, or regional dental center for all professional, technical, and administrative matters concerning dental services (sec. 4 of act of 28 Dec 1945, now codified by an act approved 10 Aug 1956 (10 U.S.C. 6029)). Therefore, the head of the dental department or branch dental clinic shall be an officer of the Dental Corps permanently attached for duty and so assigned. This

officer shall be designated the dental officer, or head, branch dental clinic.

(2) The dental officer/head, branch dental clinic is responsible for the general duties prescribed in Navy Regulations for the head of a department as well as the duties prescribed for a head of a dental department or branch dental clinic.

(3) The dental officer of a ship or station or the head, branch dental clinic of a station shall advise the commanding officer of the number and grades or ratings of dental personnel needed for efficient operation of the dental department/branch dental clinic whenever the requirements are altered appreciably because of personnel, physical facilities, or workload changes.

(4) The dental officer/head, branch dental clinic shall conduct an organized program of preventive dentistry and dental health education for all personnel. The commanding officers at regional dental centers shall designate a dental officer as the preventive dentistry officer, who shall implement the preventive dentistry program.

6-23. Assistant Dental Officer

(1) Assistant dental officers shall conform to the policies established by the dental officer/head, branch dental clinic with regard to the professional treatment and care of patients. They shall perform such other duties as may be assigned them by the dental officer/head, branch dental clinic or other competent authority.

6-24. Principal Duty of All Dental Officers

(1) The principal duty of all officers of the Dental Corps is to treat and prevent diseases, disabilities, and injuries of the jaws, teeth, and related structures. Although it is essential for dental activities to be

administered properly, it is desirable that all dental officers keep the time required for administration and supervision to an absolute minimum in order to increase their professional accomplishment.

6-25. Proficiency in All Fields of Dentistry

(1) It is desirable that all dental officers have an opportunity to become proficient in the various fields of dentistry which are practiced in the naval service. The dental officer should, insofar as may be practicable, afford assistant dental officers the opportunity to acquire experience in the various dental fields. This may be accomplished in two ways:

(a) Permit all dental officers to conduct a general practice and perform all types of dental operations and treatments.

(b) Rotate dental officers for limited periods in the various fields of dentistry.

(2) When appropriate, qualified dental officers should act as consultants and advisors to dental officers with lesser experience.

6-26. Duties Upon Reporting to Ship or Station (Regulatory)

(1) As soon as possible after reporting, the dental officer of a ship or station shall examine the dental operating spaces, the equipment therein, and other accommodations provided for the dental department. The dental officer shall make a detailed written report to the commanding officer if any defects or deficiencies are discovered which interfere with the efficient operation of the dental department.

(2) The Bureau desires full knowledge of the functioning of the Navy Dental Corps ashore and afloat in order to be prepared to anticipate and meet needs for personnel and material and be informed of the adequacy of dental treatment facilities as related to the need or demand for dental treatment. Dental officers are, therefore, encouraged to submit to the Bureau, via official channels, well considered suggestions for the improvement of the Navy Dental Corps.

6-27. Duties in Care of Combat/Contingency Casualty Situations (Regulatory)

(1) Dental officers shall be qualified to perform advanced life support resuscitative procedures during surge phases of combat/contingency situations in order that they may treat or assist in the treatment of casualties.

6-28. Organization Manuals and Directives (Regulatory)

(1) Each dental activity and dental department of a ship or station shall publish an organization book and such other directives as are necessary for the

organization and operation of the activity or department. Reference should be made to the Directives Issuance System, SECNAVINST 5215.1 series, and to BUMEDINST 5450.74 series, as applicable.

6-29. Dental Journal (Regulatory)

(1) The commanding officer of a dental activity and the dental officer of a ship or station shall maintain a journal in which shall be entered a complete, concise, chronological record of events of importance, or which may be of historical value, concerning the dental facility.

(2) Any important occurrence coming under the cognizance of the dental officer such as damage, destruction, or loss of dental department property, or breaches of discipline by dental department personnel, shall be reported to the officer of the deck or other proper official for entry in the log, report book, or journal of the ship or station.

6-30. Official Correspondence (Regulatory)

(1) All official correspondence on dental department matters shall be signed or cleared by the dental officer and forwarded through official channels.

(2) Dental reports shall be prepared and forwarded by the dental officer of a ship or station, in accordance with sections XV and XXI of this chapter, chapter 23, and current directives.

6-31. Narcotics, Alcohol, and Drugs (Regulatory)

(1) The dental officer of a ship or station shall not permit narcotics, controlled drugs, or dangerous drugs to be placed in the possession of any person, except in small quantities for use in treatment of patients (see chap. 21).

6-32. Knowledge of Official Directives (Regulatory)

(1) Instructions set forth in this manual are but a portion of the general instructions with which officers of the Dental Corps must be familiar. They shall also study various other official publications such as BUMED instructions and notices; Navy Regulations; Manual for Courts-Martial, United States, 1969, and the JAG Manual; BUPERSMAN; and other current orders and instructions.

6-33. Publication of Professional Articles (Regulatory)

(1) Dental Corps officers are encouraged to contribute to professional literature. They shall be guided by Navy Regulations, Navy Public Affairs Regulations, and current directives relating to preparation and publication requirements.

6-34. Participation in Civilian Professional Activities (Regulatory)

(1) Officers of the Dental Corps shall make every effort to establish and maintain the highest standards of ethical and professional practice, to keep themselves informed in all fields of dentistry, and to improve their professional abilities. When practicable, they should attend professional meetings of dental societies, seminars, clinics, lectures, study courses, and other similar means of acquiring additional knowledge.

(2) Dental officers shall inform BUMED, by official letter, of special incidents of interest, such as: certification by a specialty board; completion of a course of instruction or training not previously reported to the Bureau; membership in an honor society; honorary or life membership in a professional society; appointment as editor, associate editor, or

contributor on the staff of a professional publication; and similar types of accomplishment, honor, or appointment.

(3) Dental officers desiring teaching affiliations in civilian institutions shall comply with the following guidelines:

(a) Approval must be requested by official letter and granted by BUMED.

(b) Time spent teaching in civilian institutions must be no more than one-half day every other week.

(c) Such affiliations shall result in no cost to the Navy.

6-35. Off-Duty Employment (Regulatory)

(1) Officers of the Dental Corps shall comply with article 1-22 with regard to off-duty remunerative professional employment.

Section V. DENTAL OFFICERS AFLOAT

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6-37. Fleet Dental Officer (Regulatory)

(1) *Responsibilities.*—The fleet dental officer is the adviser to the fleet commander on all matters pertaining to fleet dental matters. The fleet dental officer shall, by means of inspections, visits, and review of dental service reports and reports of inspections, keep informed of all matters pertaining to the dental service, dental personnel, and dental materiel of the fleet. In addition to these general responsibilities, the fleet dental officer shall:

(a) Assist the fleet commander in preparing the dental aspects of operational and logistic plans.

(b) Coordinate dental services administered in subordinate units of the fleet, conferring with force dental officers as necessary to ensure maximum coordination.

(c) Advise the fleet commander regarding establishment, expansion, or reduction of dental facilities in ships of the fleet and the adequacy of fleet-supporting shore-based dental facilities.

(d) Recommend to the fleet commander, for submission to the Bureau, information, observations, and recommendations on matters under the Bureau's purview which would improve dental service to the fleet.

(e) Promote professional interest by the timely dissemination of information to dental officers of the fleet; and by arranging meetings of officers of the Dental Corps within the fleet, when practicable, for discussion of appropriate subjects.

(2) Inspections.—

(a) The fleet dental officer shall, when directed by the fleet commander, make inspections of dental facilities of ships of the fleet and of dental facilities of fleet shore-based activities as required.

(b) The fleet dental officer shall, when practicable, make limited inspections of dental facilities in ships of the various groups and components of the fleet and of dental facilities of fleet shore-based activities as required.

(c) The fleet dental officer may, subject to the approval of the fleet commander, visit dental facilities of fleet shore-based activities to give or obtain technical information or assistance.

(3) Scope of Inspections.—

(a) When the fleet dental officer is directed to inspect the dental organization of a ship or shore-

based activity, this officer shall comment on the efficiency of the dental organization and dental service.

(b) When the fleet dental officer visits a fleet unit or activity, this officer shall do so on an advisory and constructive basis with a view toward possible improvement of the dental service.

(4) *Outline of Inspection.*—When making an inspection, the fleet dental officer shall be guided by the general provisions of article 6-195, as applicable.

(5) Written Reports.—

(a) Following each inspection, the fleet dental officer shall make a written report to the fleet commander, via the commanding officer of the ship or activity concerned and the administrative chain of command, or to the appropriate administrative commander, if the inspection was conducted as part of an annual administrative inspection.

(b) Following each visit, the fleet dental officer shall make a written report to the fleet commander, via the commanding officer of the ship or activity concerned and the administrative chain of command.

6-38. Force Dental Officer (Regulatory)

(1) The duties of the force dental officer shall be similar to those of the fleet dental officer insofar as they relate to the force organization.

6-39. Dental Officer in a Ship (Regulatory)

(1) The head of the dental department of a ship is designated the dental officer and shall be the senior officer of the Dental Corps attached for duty. In the absence of the dental officer, the duties shall be performed by the next senior dental officer attached for duty and on board. The responsibilities and duties of a head of a department are prescribed in Navy Regulations and by the commanding officer.

(2) The primary responsibility of the dental officer is to maintain the dental health of the personnel of the ship. The dental officer and assistants will provide the dental treatment necessary to achieve this objective. Other parts of this responsibility include:

(a) Conducting dental examinations when practicable on personnel who report for duty to determine need for dental treatment and to verify their dental records.

(b) Instructing ship's personnel in preventive dentistry and instituting any measures required to control dental disease.

(c) Treating personnel from other commands who may be dependent upon the dental officer for dental service.

(d) Preparing and submitting required reports on dental treatment.

(e) Performing the duties of a division officer when assigned as such by the commanding officer. The division dental officer shall be responsible for carrying out requirements as provided in U.S. Navy Regulations. The dental division shall include all personnel assigned duty with the dental department.

(f) Providing professional advice to the commanding officer concerning proper action to be taken to obtain non-Navy dental treatment under the provisions of the BUMEDINST 6320.32 series.

6-40. Dental Officer in Aircraft Carrier (Regulatory)

(1) The provisions of article 6-39 shall apply to the dental officer in an aircraft carrier. In addition,

the dental officer shall be responsible for squadron personnel when embarked. The dental officer shall take special measures to assure that dental records of squadron personnel accompany the squadron when detached from the ship.

6-41. Dental Officer in Tender or Repair Ship (Regulatory)

(1) In addition to compliance with article 6-39, the dental officer in a tender or repair ship shall make advance arrangements and just allocation of time for the personnel from other ships.

6-42. Dental Officer Embarked With Troops in Transport

(1) See article 6-85F.

Section VI. DENTAL OFFICERS ASHORE

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6-48. Staff Dental Officer of Advanced Base (Regulatory)

(1) Dental officers serving on the staff of advanced bases shall carry out such functions as prescribed by COMNAVMECOM.

6-49. Commanding Officer of Dental Activity (Regulatory)

(1) The commanding officer of a dental activity is detailed as such by the Navy Department from the officers of the active list of the Dental Corps.

(2) The commanding officer is charged with the direction of the professional and command functions of the activity. This officer shall be guided by Navy Regulations and instructions governing commanding officers.

(3) In the absence of the commanding officer of a naval dental clinic, the executive officer, so detailed by the Commander, Naval Military Personnel Command, shall succeed the commanding officer. In the event of permanent incapacity or death of the commanding officer, the designated successor will serve until a new commanding officer is designated by higher competent authority.

6-50. Officer in Charge of Dental Activity (Regulatory)

(1) The officer in charge of a dental activity is detailed as such by the Navy Department from the officers of the active list of the Dental Corps.

(2) The officer in charge of a dental activity shall be guided, where pertinent, by the provisions of article 6-49(2).

6-51. Dental Officer in Shore Station (Regulatory)

(1) The Director, Branch Dental Clinic, or the head of the dental department of a shore station is designated the dental officer and shall be an officer in the Dental Corps attached for duty and so assigned. In the absence of the dental officer, the duties

shall be performed by the next senior dental officer regularly attached to and serving on board for duty.

(2) In addition to those general duties prescribed in Navy Regulations and by the commanding officer for the branch director or head of a department, the dental officer shall:

(a) Be responsible for maintaining the dental health of the personnel attached to the shore station.

(b) Conduct dental examinations on all personnel, if practicable, when they report for duty to determine their requirements for dental treatment and to verify their dental records.

(c) Be responsible for the instruction of station personnel in preventive dentistry and institute any measures required to control dental disease.

(d) Be responsible for the treatment of personnel from other commands who may be dependent upon the branch dental clinic or dental department for dental service.

(e) Supervise the performance of duty of all personnel assigned to the branch dental clinic or dental department.

(f) Conduct a program of inservice training for all personnel on duty in the branch dental clinic or dental department on appropriate subjects for improving their knowledge and increasing their efficiency.

(g) Provide professional advice to commanding officers concerning proper action to be taken to obtain non-Navy dental treatment under the provisions of NAVMEDCOMINST 6320.1 series.

6-52. Head of Dental Department in Hospital (Regulatory)

(1) The senior dental officer attached for duty in a hospital shall normally be the head of the dental department, and shall have the same status in relation to the commanding officer, and to the executive officer, via the director of surgical services, as other heads of departments on the hospital staff.

(2) The primary function of the dental department is to treat patients, and all other activities, except essential training, shall be minimized.

(3) The head of the dental department shall:

(a) Provide dental care for patients and personnel of the staff and for such other personnel listed in article 6-98 as are dependent upon the hospital for dental care.

(b) Provide care for diseased or traumatized conditions of the oral region, mandibular or maxillary fractures, cysts and tumors of dental origin, cysts and tumors involving the teeth and surrounding structures, and closing of maxillary antral openings of dental origin. The head of the dental department and staff shall consult with medical officers whenever the interest of patients so requires, particularly when mutual professional fields are involved.

(c) Act in an advisory capacity to the commanding officer in all matters relating to dentistry and the dental department.

(d) Supervise the performance of duty of all personnel assigned to the dental service.

(e) Conduct a program of inservice training for all personnel on duty in the dental department.

(f) Conduct dental general practice and oral surgery residency programs, when authorized, in accordance with current COMNAVMECOM instructions.

(g) Participate in those staff meetings which are pertinent to the efficiency of the dental department.

6-53. Dental Officer in Research Activity or Facility (Regulatory)

(1) A limited number of dental officers with research ability or training may be assigned to research facilities.

(2) In addition to the policy and general duties prescribed in chapter 20, dental officers assigned to research facilities shall:

(a) Conduct scientific investigations related to problems in Navy dentistry or as may be prescribed by the commanding officer.

(b) Act in an advisory capacity to the commanding officer, through the chain of command, on all dental and oral research matters.

6-54. Offices of Dental Affairs (Regulatory)

(1) With CNO's disestablishment of the offices of the commandants of naval districts (except NAVDIST WASH, DC), the Naval Medical Command designated certain of its dental commands, and senior dental officers at certain medical clinics, and NAVDIST WASH, DC to assume responsibilities formerly under the cognizance of district dental officers. These designated activities are referred to as offices of dental affairs (ODA).

(2) Each ODA is responsible for continued administration of:

(a) The nonnaval dental care program, including the review, approval, and disapproval of dental treatment plans and adjudication of dental care claims.

(b) Other dental administrative matters as assigned by COMNAVMECOM and delineated in NAVMEDCOMINST 6010.3 series.

(3) NAVMEDCOMINST 6320.1 series delineates the ODAs and their geographical areas of responsibility.

Section VIII. DENTAL TECHNICIANS

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6-62. Mission

(1) The Dental Technician (DT) Rating has a twofold mission:

(a) The primary function is to assist Navy dental officers in providing such care for active duty Navy and Marine Corps as will prevent or remedy diseases, disabilities, and injuries of the teeth, jaws, and related structures, which may directly or indirectly interfere with operational readiness and the performance of military duties.

(b) During combat, mass casualty, or emergency situations at sea or ashore, dental technicians shall, when directed, integrate with medical personnel and perform paramedical assignments. This assistance shall include, but not be limited to, aid in the care, treatment, and evacuation of mass casualties in combat or disaster. Emergency care or treatment to include artificial respiration, treatment of shock, control of hemorrhage, bandaging and splinting, cleansing and treatment of wounds, maintenance of patient airway, and the preparation of casualties for movement. Dental technicians shall be under the direct supervision of the cognizant Navy Medical Corps officer(s), if present.

6-63. Establishment of Dental Technician Rating, Occupational Field XIV

(1) The Dental Technician Rating, Occupational Field XIV Health Care, was first established as a separate occupational group (Group XI Dental) in the enlisted rating structure by the Secretary of the Navy on 12 December 1947, effective 2 April 1948, at which time dental technicians of the Navy were authorized to wear the dental rating badge. In 1977, the enlisted rating structure was revised from groups to occupational fields with ratings having a common purpose being placed into the same occupational field. Group X (hospital corpsmen) and Group XI (dental technicians) were placed into Occupational Field XIV Health Care as promulgated in the Manual of Naval Enlisted Manpower and Personnel Classification and Occupational Standards, NAVPERS 18068D.

(2) The Dental Technician Rating, Occupational Field XIV is comprised of personnel trained to assist

Navy dental officers in providing dental care for the personnel of the Navy and Marine Corps. Additionally, personnel are trained to assist with and render emergency medical care during combat or mass casualty evolutions. This group consists of the single general service rating of dental technician. Dental recruit, dental apprentice, and dentalman are general apprenticeships which lead to the dental technician rating.

(3) Occupational Field XIV dental constitutes the general service dental technician rating group. The dental technicians are as follows:

<i>Rate</i>	<i>Rate abbreviation</i>	<i>Pay grade</i>
Dental recruit	DR	E-1
Dental apprentice	DA	E-2
Dentalman	DN	E-3
Dental technician, third class	DT3	E-4
Dental technician, second class	DT2	E-5
Dental technician, first class	DT1	E-6
Chief dental technician	DTC	E-7
Senior chief dental technician	DTCS	E-8
Master chief dental technician	DTCM	E-9

6-64. Entry Into Dental Technician Rating, Occupational Field XIV

(1) Candidates for the Dental Technician Rating, Occupational Field XIV, must be qualified in accordance with current NAVMILPERSCOM and COMNAVMEDCOM directives. Candidates are procured from the following sources:

(a) Applicants for enlistment in a dental rate.
(b) Quotas of recruit trainees at naval training centers.

(c) Volunteer applicants (strikers) from within the naval service.

(2) Completion of Dental Assistant, Basic (Class A School) is a prerequisite for assignment to the Dental Technician Rating, except in time of national emergency. Waivers may be granted for certain Reserves or inductees who have had previous training equivalent to the basic course.

(3) Qualifications for entrance to Dental Assistant, Basic (Class A School) are contained in the Catalog of Navy Training Courses (CANTRAC) NAVEDTRA 10500 and current NAVMILPERSCOM and COMNAVMEDCOM directives.

6-65. Training—Dental Technician Rating

(1) Enlisted personnel receive their initial training in dental assisting at the Dental Assistant, Basic (Class A School).

(2) Completion of Class A School is normally a prerequisite for a dental technician to apply for specialized or advanced training in Class C Schools.

(3) Information regarding schools available to enlisted personnel, dental assisting, technology and related fields may be found in articles 6-139 through 6-144B and the Catalog of Navy Training Courses (CANTRAC), NAVEDTRA 10500.

(4) In addition to the training provided in basic, specialized, and advanced dental technicians schools, enlisted dental personnel, up to and including dental technician, first class, should receive organized inservice training and instruction, in accordance with current COMNAVMECOM directives.

(5) Dental Corps and Medical Service Corps officers attached to dental activities and dental technicians may be used as instructors in the inservice training programs.

6-66. Advancement in Dental Technician Rating, Occupational Field XIV

(1) Enlisted dental personnel shall be examined for advancement in accordance with current NAVMILPERSCOM directives. When examinations for advancement are prepared locally, the membership of the examining board shall, when practicable, consist of at least one dental officer or a Medical Service Corps officer assigned to a dental activity.

(2) Enlisted dental personnel must be familiar with the Manual of Navy Enlisted Manpower and Personnel Classifications and Occupational Standards, NAVPERS 18068D, and satisfy the Personnel Advancement Requirement (PAR) Program for their rate.

6-67. Assignment and Duties of Enlisted Dental Personnel

(1) *Assignment.*—Enlisted dental personnel are assigned to naval dental clinics, naval hospitals, naval medical clinics, dental departments of ships and stations, Fleet Marine Force dental battalions and companies, and mobile construction battalions as technical assistants to dental officers. During mass casualty or emergency evolutions at sea or ashore, dental technicians are assigned to assist and integrate with medical personnel as required. They are assigned to such other duties as may be indicated by their special qualifications and by current requirements for dental care.

(2) *General Duties.*—Members of the dental technician rating shall be qualified to perform the following duties:

(a) Keep dental appointment and office records.

(b) Prepare dental records, including dental charts, under the direction of dental officers.

(c) Prepare routine and special reports and forms.

(d) Keep precious metal records and prepare reports in connection therewith.

(e) Perform oral prophylactic treatments under the supervision of dental officers.

(f) Perform preventive dentistry treatment and instruct patients in oral hygiene.

(g) Render dental first aid.

(h) Expose and process dental X-ray films, as prescribed by written or verbal order of a dental officer.

(i) Prepare materials and medication utilized by dental officers.

(j) Sterilize and sharpen instruments.

(k) Provide preventive maintenance of dental equipment.

(l) Maintain cleanliness of dental spaces.

(m) Render emergency medical aid to casualties of war or peacetime disaster.

(n) Perform such other duties in caring for dental patients and dental facilities as may be directed by those in authority.

(3) *Dental Recruit (DR).*—A dental recruit, when enlisted will be sent to a naval training center with other recruits for indoctrination and basic training. Upon completion of recruit training and if considered to have satisfactory aptitude, the individual will be assigned to Class A School for Dental Assistant, Basic (Class A School).

(4) *Dental Apprentice (DA).*—Dental apprentices are personnel in training for advancement to dentalman. They shall perform elementary routine duties as dental operating room and clerical assistants. They may be assigned to assist and augment the medical effort during contingency evolutions.

(5) *Dentalman (DN).*—Dentalmen are personnel in training for advancement to the rating of dental technician third class. In addition to acting as dental operating room assistants, they shall perform duties such as equipping dental cabinets, cleaning and maintaining dental equipment, preparing trays for impressions, boxing and pouring impressions, polishing simple prosthetic appliances, and performing routine clerical duties. They may be assigned to assist and augment the medical effort during contingency evolutions.

(6) *Dental Technician, Third Class (DT3).*—Dental technicians, third class, shall perform various types of dental clinical and clerical duties such as assisting dental officers in the treatment of patients, performing prophylactic treatments under supervision of dental officers, rendering dental first aid, and carrying out dental department administrative assignments. As junior petty officers, they may

assist with dental property records and may be placed in charge of dental supplies issue rooms. They may be assigned to assist and augment the medical effort during contingency evolutions.

(7) *Dental Technician, Second Class (DT2)*. — Dental technicians, second class, shall perform duties commensurate with their rate. They shall render dental first aid, perform dental prophylactic treatments under the supervision of dental officers; perform routine clerical, property, and clinical duties; take charge of dental watch sections; act as mate of the day; and supervise and instruct lower rated personnel in their duties. They may be assigned to assist and augment the medical effort during contingency evolutions. They may be assigned duty as instructors in dental technician schools.

(8) *Dental Technician, First Class (DT1)*. — Dental technicians, first class, shall perform duties commensurate with their rate. They may be placed in charge of a dental ward, record office property section, or dental prosthetic laboratory. They may be assigned duty as instructors in dental technician schools. They may prepare watch, quarter, and station bills; instruct and supervise lower rated personnel; perform clinical duties; render dental first aid and administer dental prophylactic treatments under the supervision of dental officers. They may serve as mate of the day or assistant chief of the day. They may be assigned to assist in the treatment and management of mass casualties, and the training of personnel for contingency roles. When eligible, they may apply for appointment as a commissioned officer in the Medical Service Corps or in any other available Navy program.

(9) *Chief Dental Technician (DTC)*. — Chief dental technicians shall perform duties commensurate with their rate. They may be placed in charge of a dental ward, record office, property section, or dental prosthetic laboratory. They may be assigned duty as instructors in dental technician schools. They may serve as chief master of arms. They may

prepare watch, quarter, and station bills; detail enlisted personnel with a view to their most efficient employment; and instruct lower rated personnel. They may supervise certain technical procedures, render dental first aid, and perform dental prophylactic treatments under the supervision of dental officers. They may be assigned to assist in the management and evacuation of mass casualties, and the training of personnel for contingency roles. When eligible, they may apply for appointment as a commissioned officer in the Medical Service Corps or in any other available Navy program.

(10) *Senior Chief Dental Technician (DTCS)*. — Senior chief dental technicians shall be assigned duties commensurate with their rate. They may be assigned duties greater in scope and of greater responsibility than those of a chief dental technician. They may be utilized in the larger dental facilities where their capabilities and experience as administrative and technical assistants are required. They may be assigned to formulate and coordinate contingency and disaster (medical) preparedness plans. When eligible, they may apply for appointment as a commissioned officer in the Medical Service Corps or in any other available Navy program.

(11) *Master Chief Dental Technician (DTCM)*. — Master chief dental technicians shall be assigned duties commensurate with their rate. They may be assigned duties greater in scope and of greater responsibility than those of a senior chief dental technician. They may be utilized in the larger dental facilities where their capabilities and advanced experience as administrative and technical assistants are required to provide a more efficient dental service. They may be assigned to formulate and coordinate contingency and disaster (medical) preparedness plans. When eligible, they may apply for appointment as a commissioned officer in the Medical Service Corps or in any other available Navy program.

Section IX. MEDICAL SERVICE CORPS OFFICERS AND NURSE CORPS OFFICERS IN DENTAL FACILITIES

	Article
Assignment and Duties of Medical Service Corps Officers in Dental Facilities (Regulatory)	6-72
Assignment of Nurse Corps Officers in Dental Facilities	6-73

6-72. Assignment and Duties of Medical Service Corps Officers in Dental Facilities (Regulatory)

(1) *Assignment.*—Medical Service Corps officers are assigned to dental commands and staffs to supervise administrative procedures so that dental officers can devote more time to clinical duties. They normally are assigned as:

- (a) Executive assistants to the Chief of the Dental Division and the Inspector General, Dental.
- (b) Directors of administrative services in dental commands.
- (c) Finance officers in dental commands.
- (d) Heads of administrative departments in large dental commands.

(e) Company commanders and executive officers of Headquarters and Service Companies of force dental battalions.

(f) Administrative officers to dental officers on staffs of major commands.

(2) *Duties.*—The duties of Medical Service Corps officers require that they keep informed on regulations, policies, and instructions pertaining to the administrative support of dental commands. They shall:

(a) Manage administrative functions for dental commands including budgeting, accounting, property procurement and distribution, and preparation of required records, reports, and correspondence.

(b) Assist in dental planning and logistics duties on major staffs.

(c) Assist the Inspector General, Dental, and designated assistant inspectors general in administrative surveys and inspections of dental commands, departments, and clinics.

(d) Act as supervisor of the inservice training program in dental facilities and act as an instructor in administration at dental facilities and dental technician schools.

6-73. Assignment of Nurse Corps Officers in Dental Facilities

(1) Where feasible, officers of the Nurse Corps should be assigned to the oral surgery branch of teaching hospitals and regional dental centers.

(2) The Bureau considers that such assignments directly benefit the patients through the promotion of high professional standards of oral surgical treatment, and permit maximum professional utilization.

Section X. CIVILIAN EMPLOYEES IN DENTAL FACILITIES

General Information	Article 6-74
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6-74. General Information

(1) Instructions for the employment of civilian personnel are contained in chapter 10.

(2) Care should be taken to assure that the employment of civilians does not interfere with the duties, rotation, and training of naval personnel.

Section XI. NAVAL REGIONAL DENTAL CENTERS AND BRANCH DENTAL CLINICS

	Article
Definitions and Establishment	6-75
Mission	6-76
Organization	6-77
Commanding Officer (Regulatory)	6-78
Director of Clinical Services (Regulatory)	6-79
Director of Administrative Services (Regulatory)	6-80
Heads of Clinical and Administrative Departments	6-81

6-75. Definitions and Establishment

(1) A *naval regional dental center* is an established shore activity and is the principal organizational entity in the dental health care delivery system. A dental center is duly established, appropriately staffed and equipped to provide comprehensive outpatient dental health care for authorized personnel, including a wide range of specialized, consultative and administrative support for all dental facilities within the geographical area of responsibility. A dental center may be authorized to provide for advanced education in the arts and sciences of dentistry.

(2) A *dental clinic* is a dental health care facility capable of providing comprehensive dental health care, but is dependent upon consultative, administrative, and financial support from its dental center.

(3) Naval regional dental centers are established by authority of the Secretary of the Navy in accordance with OPNAVINST 5450.169 series.

(4) *Branch dental clinics* are assigned to a naval regional dental center by the Chief of Naval Operations.

(5) *Justification*.—Establishment of a naval regional dental center is indicated since through such an organization dental care can be provided most efficiently to the Operating Forces and to shore (field) activities of the Department of the Navy for which the dental command is responsible.

(6) *Command Relationship*.—Naval regional dental centers are echelon 3 commands under the professional direction, guidance, and supervision of the Bureau of Medicine and Surgery. Area coordination is assigned by the Chief of Naval Operations to one of the area coordinators or fleet commanders. Naval regional dental centers must receive logistic support from nearby activities since they are not self sustained.

6-76. Mission

(1) To provide a complete dental service to Navy and Marine Corps shore activities, units of the Operating Forces, and other authorized personnel in the assigned geographic area. To provide coordinated dental health care services as an integral element of the Naval Regional Health Care System including

shore activities as may be assigned. Perform such other functions or tasks as may be directed by the Chief, Bureau of Medicine and Surgery.

6-77. Organization

(1) A sample organization chart for a naval regional dental center is shown on the following page.

(2) Naval regional dental centers organization charts and manuals will be in the format presented in BUMEDINST 5450.143 series.

(3) The commanding officers shall be the officers assigned as such by the Commander, Naval Military Personnel Command.

6-78. Commanding Officer (Regulatory)

(1) *General Duty*.—The commanding officer is charged with the command, organization and management of regional dental centers for the purpose of accomplishing the mission as efficiently, effectively and economically as possible. Subject to the orders of higher authority, the commanding officer exercises complete military jurisdiction within the command and is responsible for the professional care of patients and for the safety and well-being of the entire command. Duties and responsibilities of the commanding officer are prescribed in *Navy Regulations* and this manual.

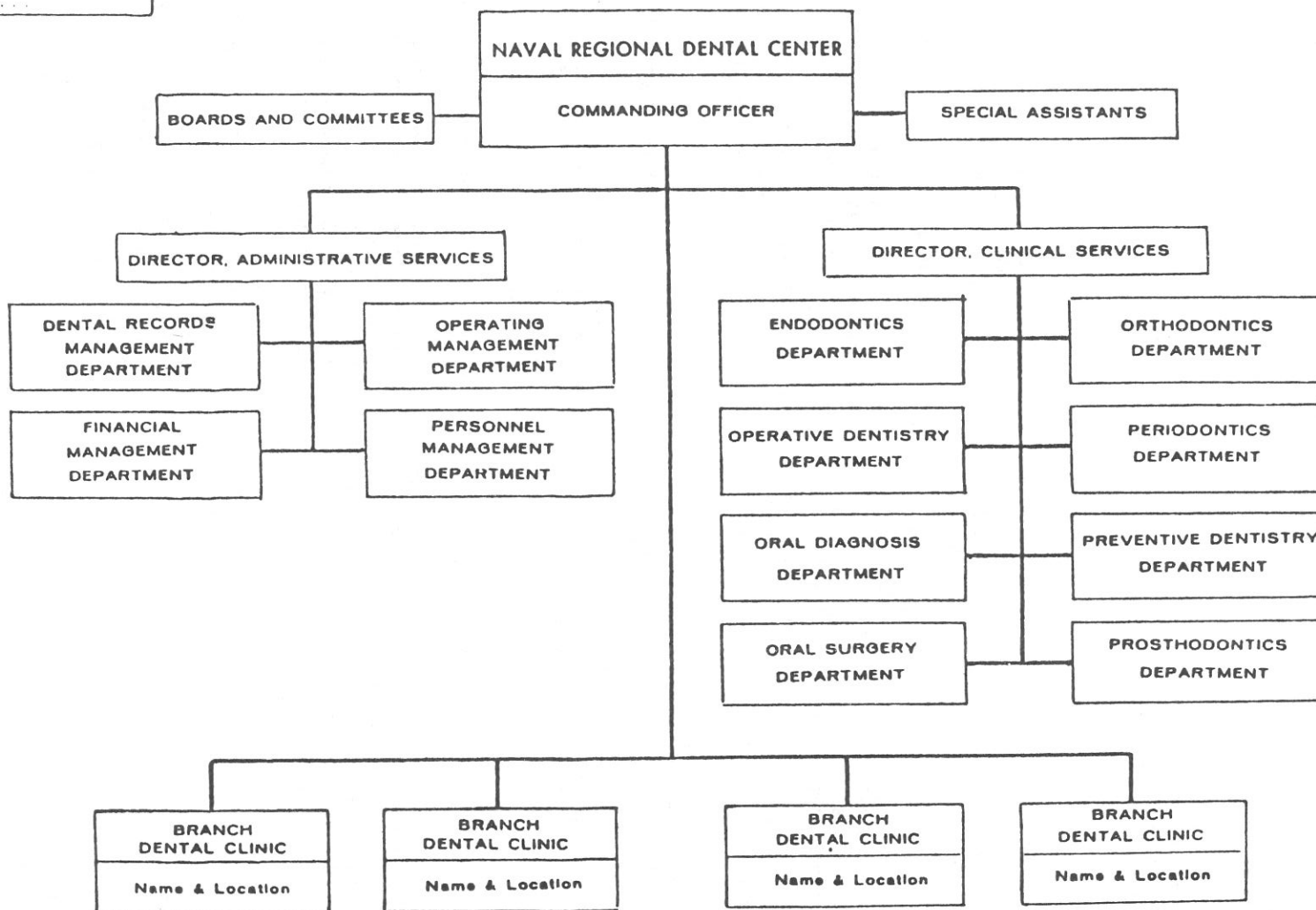
(2) When a patient being provided care in a naval regional dental center requires dental care beyond the capabilities of the dental center and of other Federal medical and dental facilities in the area, the commanding officer may utilize and direct the utilization of supplemental services and supplies from civilian non-Federal sources. This is limited to the services of a dentist, specialist, or dental laboratory technician. Specific guidelines with respect to the dental care authorized for dependents are contained in the SECNAV Instruction 6320.8 series. Costs incurred are chargeable to the naval regional dental center's maintenance and operation allotment.

(3) *Specific Duties*.—

(a) Maintain liaison with the commanding officer of the local regional medical center and host activities.

NOTES: (Example)
1. Personnel
Services provided by
NS . . .

BASIC ORGANIZATION CHART FOR NAVAL REGIONAL DENTAL CENTERS



(b) Maintain an accurate logistic support mobilization plan and ensure its integration in mobilization as directed by the assigned area coordinator.

(c) Ensure compliance with directives issued by competent authority.

(d) Advise the host activities of the dental health profile of their respective personnel and provide for their improvement.

(e) Inspect facilities and equipment to ensure operational readiness.

(f) Provide for orientation, indoctrination, refresher and familiarization training, and specialty rotation where practicable.

(g) Maintain an adequate professional library of standard textbooks and current periodicals.

(h) Confer with civilian consultants on matters concerning clinical or administrative requirements, as applicable.

(i) Establish cooperative and cordial relationships with civilian professional organizations.

6-79. Director of Clinical Services (Regulatory)

(1) *Assignment.*—The director of clinical services shall be the officer assigned as such by the Commander, Naval Military Personnel Command from among the officers of the Dental Corps.

(2) *Responsibility.*—The director of clinical services is responsible to the commanding officer for the coordination and efficient operation of the clinical functions of the command. All orders of the director of clinical services shall be regarded as proceeding from the commanding officer whose policies and orders shall be conformed with and executed. The director acts independently upon matters which do not require the personal attention of the commanding officer, but keeps the commanding officer apprised of actions taken. The director shall keep informed of current policies so that if so directed by the commanding officer, this officer may assume command in the absence of the commanding officer.

(3) *Functions.*—The primary function of the director of clinical services is to assist the commanding officer in discharging those responsibilities of the commanding officer for the care and treatment of patients, the clinical training of the staff, the formu-

lation of clinical policies and directives, and in the coordination of the clinical matters of the command. The director of clinical services shall assure that the acceptable standards for delivery of oral health care are maintained.

6-80. Director of Administrative Services (Regulatory)

(1) *Assignment.*—The director of administrative services shall be the officer assigned as such by the Commander, Naval Military Personnel Command from among the officers of the Medical Service Corps.

(2) *Responsibility.*—The director of administrative services is responsible to the commanding officer for the coordination and efficient operation of the administrative and management functions of the command. All orders of the director of administrative services shall be regarded as proceeding from the commanding officer, whose policies and orders shall be conformed with and executed.

(3) *Functions.*—The director of administrative services primary functions are to assist the commanding officer in discharging those responsibilities of the commanding officer for management, administration and coordination of the command; the formulation of administrative policies, standards, and directives; and responsibility for the management improvement functions for the command.

6-81. Heads of Clinical and Administrative Departments

(1) *Assignment.*—Heads of clinical and administrative departments are assigned as such by the commanding officers and are responsible for the execution of their assigned duties as directed by the commanding officer.

(2) *Responsibilities.*—Heads of clinical and administrative departments are responsible to the directors of clinical and administrative services respectively as directed by the commanding officer.

(3) *Function.*—Conduct and coordinate the patient care and administrative functions of the naval regional dental center in an efficient and orderly manner.

Section XII. DENTAL SERVICE SUPPORT, FLEET MARINE FORCE

	Article
Establishment	6-82
Organization	6-83
Mission	6-84
Command Relationships (Regulatory)	6-85
Dental Officer on Staff of Commandant of U.S. Marine Corps (Regulatory)	6-85A
Dental Officer on Staff of Commanding General, Fleet Marine Force (Regulatory)	6-85B
Commanding Officer, Force Dental Battalion, Force Service Support Group (Regulatory)	6-85C
Commanding Officer, Force Dental Company (Regulatory)	6-85D
Commanding Officer of Headquarters and Service Company (Regulatory)	6-85E
Dental Officer Embarked With Troops in Transport (Regulatory)	6-85F
Assignment and Duties of Enlisted Dental Personnel	6-85G
Training	6-85H
Dental Supplies and Equipment	6-85I
Planning Dental Facilities	6-85J
Inspection of Marine Corps Dental Activities and Facilities	6-85K

6-82. Establishment

(1) Force dental companies were established by the Commandant of the U.S. Marine Corps to provide a flexible, mobile dental service for the Fleet Marine Force. The initial table of organization for force dental companies was approved by the Commandant on 17 November 1954.

(2) The Commandant of the Marine Corps signed a Table of Organization in July 1955 authorizing the Force Dental Company (Ground). Soon thereafter, the 1st, 2nd, 3rd, 4th, and 5th Dental Companies were formed. The Division of Aviation, Headquarters, U.S. Marine Corps, accepted the dental company concept in June 1956 and in January 1957 the 11th, 12th, and 13th Dental Companies (Aviation) were formed. To eliminate the situation of two Tables of Organization with the same mission, a single Table of Organization for a dental company was approved.

(3) A force dental battalion was established by the Commandant of the U.S. Marine Corps to provide dental service support for the Fleet Marine Force. The initial Table of Organization for a Force Dental Battalion was approved by the Commandant on 20 August 1979. Implementation of the dental battalion organization was on 1 October 1979.

6-83. Organization

(1) A force dental battalion is commanded by a dental officer, Dental Corps, United States Navy. The dental battalion Table of Organization (T/O) is composed of 73 dental officers, 2 Medical Service Corps officers, 123 dental technicians, and 4 enlisted Marines. Dental battalions provide dental service support to the Fleet Marine Forces as a unit of the Force Service Support Group.

(2) Each dental battalion (DENBN) is organized into four companies. A headquarters and service

company (H & S CO), and three separate dental companies (DENCO). The administrative and logistic services are centralized in the headquarters and service company. The individual dental companies provide dental service support for a division, wing, force service support group, or brigade to which they have been assigned. (See diagram.)

6-84. Mission

(1) The mission of the dental battalion is to provide a level of dental service support that will maintain the optimum number of personnel in a dental condition of combat readiness.

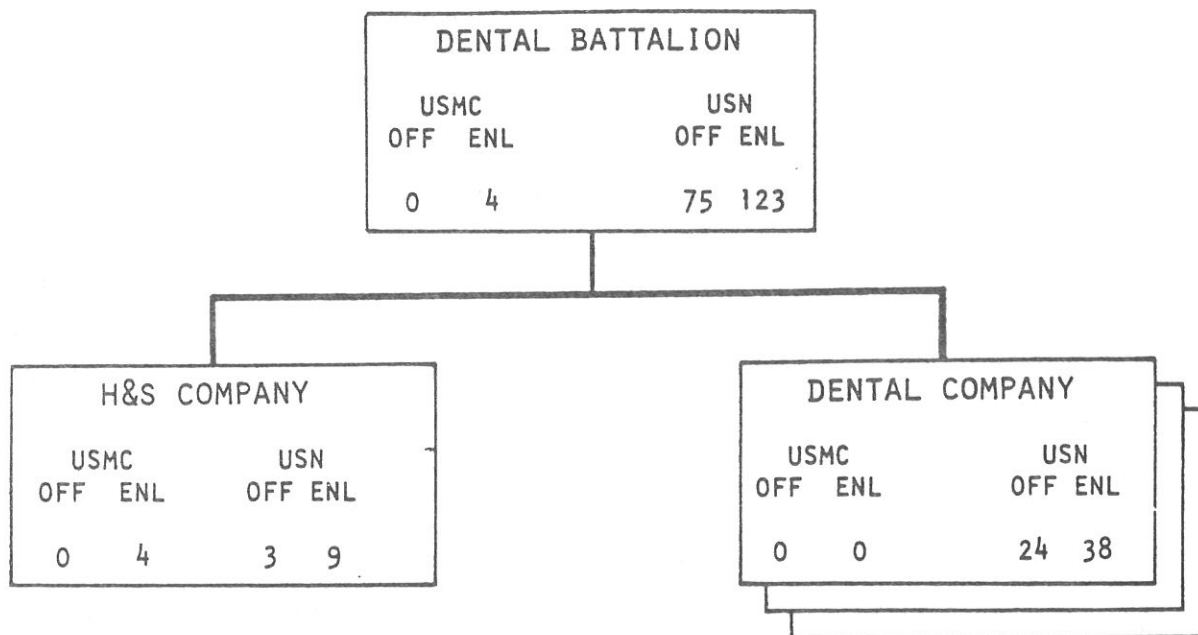
6-85. Command Relationships (Regulatory)

(1) Force dental battalions are under the administrative and operational control of the commander of the force service support group to which they have been assigned and therefore, are responsive to the directives of that commander.

(2) The commanding officer of a dental battalion will serve as a special staff officer on the staff of the force service support group supported. The commanding officer of a dental company will be designated by the commanding officer of the dental battalion as assistant staff dental officer, as required, for a Marine division, Marine aircraft wing, brigade, or force service support group.

6-85A. Dental Officer on Staff of Commandant of U.S. Marine Corps (Regulatory)

(1) The Dental Officer, U.S. Marine Corps, is a member of the special staff of the Commandant of the Marine Corps and advises the Commandant and the staff on all matters pertaining to dental services.



In coordination with appropriate members of the Commandant's staff, the dental officer shall:

(a) Determine requirements for, receive, review, and make recommendations concerning utilization of dental service support assigned the Marine Corps.

(b) Initiate action as appropriate to obtain dental personnel and materiel requirements to meet Marine Corps needs.

(c) Plan and formulate landing—force and field—dental procedures, doctrines, and programs.

(d) Survey dental organizations attached to the Marine Corps supporting establishment in coordination or in conjunction with the Inspector General, Marine Corps, and the Inspector General, Dental.

(e) Serve as BUMED (MED 04D) Marine Corps Liaison Officer, thereby, maintaining liaison between the Commandant of the Marine Corps and the Assistant Chief of Dentistry and the Chief of the Dental Division, Bureau of Medicine and Surgery, on all matters relative to the dental service support of the Marine Corps.

(f) Review dental reports submitted by Fleet Marine Forces.

6-85B. Dental Officer on Staff of Commanding General, Fleet Marine Force (Regulatory)

(1) The force dental officer of a Fleet Marine Force is a member of the special staff of the force commander and as such, advises the force commander relative to the efficient employment of force dental units. The force dental officer shall ensure that recommendations are provided for adequate dental service support in all appropriate instructions and plans and is responsible for the inspection of dental units attached to the Force.

6-85C. Commanding Officer, Force Dental Battalion, Force Service Support Group (Regulatory)

(1) The dental officer in command of a force dental battalion, as member of the special staff of the force service support group to which attached, shall advise the commander on all dental technical, professional, and administrative matters pertaining to dental service support. The commanding officer of a dental battalion shall:

(a) Ensure that maximum dental treatment is provided consistent with assigned duties, in accordance with BUMED directives.

(b) Conduct such field training as to ensure unit readiness to support appropriate Fleet Marine Force units under field conditions.

(c) Ensure that records are kept and required reports are submitted.

(d) Coordinate the operations of the force dental battalion with the overall plans, procedures, and operations of the command to which attached.

(e) Coordinate with the medical officer of the command to which attached for the temporary integration of dental personnel to assist in the care, treatment, and evacuation of casualties in combat and disaster.

6-85D. Commanding Officer, Force Dental Company (Regulatory)

(1) The commanding officer of a force dental company, as a member of the special staff of the commanding general of a division, wing, force service support group, or brigade, to which assigned, shall advise the commander on all dental technical, professional, and administrative matters pertaining to dental service support.

(2) The commanding officer of a force dental company shall:

(a) Report all matters of dental service support for the assigned division, wing, force service support group, or brigade to the commanding officer of the force dental battalion.

(b) Serve additional duty as head, branch dental clinic at those activities as indicated by higher authority.

6-85E. Commanding Officer of Headquarters and Service Company (Regulatory)

(1) See article 6-72(1)(f).

(2) The commanding officer of the headquarters and service company is responsible to the commanding officer of the force dental battalion for command administration and supply services for the battalion.

6-85F. Dental Officer Embarked With Troops in Transport (Regulatory)

(1) The senior dental officer embarked with troops in a transport shall:

(a) Report to the dental officer of the transport upon embarkation and arrange for the use of the facilities of the dental department.

(b) Be responsible for the dental health of the embarked troops while they are aboard the transport.

(c) Advise the troop commander regarding the availability of dental treatment for embarked troops.

(d) Establish a duty schedule for other troop dental officers.

(e) Advise the troop commander regarding the assignment of troop dental enlisted personnel to duties in the dental department of the ship.

6-85G. Assignment and Duties of Enlisted Dental Personnel

(1) See article 6-67.

6-85H. Training

(1) *Technical Proficiency.*—Within elements of command, technical proficiency must be maintained at all times. In addition to this requirement, dental personnel of the Fleet Marine Force receive special training in the following categories:

- (a) Field medical service school
- (b) Casualty care
- (c) NBC warfare
- (d) Field training

(2) *Field Training.*—Fleet Marine Force dental personnel must be trained in operational field procedures to ensure that they are prepared to undertake deployed duty as individuals or as a member of a detachment of an FMF dental unit. Certain types of training must be conducted while the dental units are in—garrison:

(a) Dental battalion and dental company commanding officers participate in planning and execution of command post exercises (CPX's).

(b) Dental companies participate in various types of Marine Corps training exercises, e.g., cold weather, desert, embarkation, etc.

(c) Dental field equipment familiarization for recently reported or soon to be deployed FMF dental personnel.

(d) Lectures and demonstrations on subjects pertaining to field exercises that personnel are most likely to encounter, e.g., gas mask, live ordinance, 782 gear, familiarization firing, etc.

6-85I. Dental Supplies and Equipment

(1) Technical dental field equipment and supplies consist of items needed by the dental battalion to carry out its mission of dental service support in the field. These materials are supplied in the authorized dental allowance lists (ADAL's).

(2) The basic outfit for a dental officer (dental equipment set, operating field) is an assembly of dental equipment and supplies functionally packed in sets, kits, and outfits for convenience in handling.

(3) When the dental battalion goes into combat, it must have certain nontechnical items of equipment to function properly. This equipment, furnished by the Marine Corps, is listed in the table of equipment (T/E) and includes such items as tents, trucks, and trailers.

(4) The table of equipment items are requisitioned from the Marine Corps unit designated to furnish logistic support to the dental battalion. The storage and maintenance of these items is the responsibility of the force service support group to which attached.

6-85J. Planning Dental Facilities

- (1) See article 6-186(1).

6-85K. Inspection of Marine Corps Dental Activities and Facilities

(1) Marine Corps activities shall normally be inspected or visited biennially by the Dental Officer, U.S. Marine Corps and annually by the dental officer on the staff of the Commanding General, Fleet Marine Force, Atlantic or Pacific, as appropriate.

- (2) Scope of Inspections.—See article 6-195.

Section XIII. DENTAL STANDARDS

	Article
Where To Find	6-86
Waivers of Dental Defects	6-87

6-86. Where to Find

(1) Following is a resume of subjects and applicable articles relating to dental standards:

	Articles
Annual/triennial, officer ..	15-10(5), 15-52(4)(a)(4)
Antarctica duty	15-37(3)(m)
Appointment to warrant or commissioned grade	15-10(8), 15-49
Aviation:	
Class 1, service group I	15-70(8)
Flight training candidates	15-10, 15-70(8), 15-75(1)(e), 15-76(2)
Diving	15-32(2)(f), 15-36(4)(d)
Enlistment, reenlistment, induction ..	15-30-2-5
General information	15-10(1) and (3)
Mess management specialists	15-60
Nuclear field	15-33(1)(c)
Nuclear shore power program	15-34, 15-37
Officer candidates	15-10(9), 15-50
Prisoners	15-61
Promotion, officers on	
active duty	15-10(4), 15-55
Radiation workers	15-35
Reserve components	15-82-88
Retention criteria:	
General	15-7
Nuclear field	15-33
Orthodontic	15-10(3)
Reserve	15-82(2)
Submarine personnel	15-32(2)(f)
Retired members ordered to active duty ..	15-51
Separation from active duty	15-56
State Department duty	15-38
Submarine duty	15-32(2)(f)
Transfer of personnel (officer and enlisted)	
To a ship or station with no dental officer	15-10(6)
Within the U.S. (except to isolated duty stations) or from overseas or sea duty to the U.S.	15-57(1)
To sea or overseas duty, or to isolated duty stations within the U.S.	15-57(2)
Not physically qualified for transfer ..	15-57(3)
Notification of noncompliance	15-57(5)
Women	15-10(7)

6-87. Waivers of Dental Defects

(1) When, in the opinion of the dental examiner and the commanding officer or the officer in charge of the examining facility, a waiver of any disqualifying defect is warranted, a recommendation to that effect may be submitted on the Standard Form 88 for consideration.

(2) Defects which may be waived are those which, although disqualifying in accordance with naval physical standards, will not interfere with the examinee's ability to perform the duties in the prospective grade or rate.

(3) The recommendation for waiver shall be entered on the reverse side of the Standard Form 88. The defects shall be fully described.

(4) When a physical examination is conducted incident to assignment of a Navy or Marine Corps reservist to active duty, exclusive of active duty for training, the commanding officer or officer in charge is authorized, upon the recommendation of the dental examiner, to grant a conditional waiver for any defect which in all probability will not interfere with the member's performance of active duty. The conditional waiver carries with it the authority to consider the member physically qualified to active duty prior to final review of the records in the Navy Department. When granted, the member shall be so advised and the conditional waiver shall be reported on the reverse side of the Standard Form 88. The reporting procedure is identical to that applicable to a recommendation for waiver.

(5) There is a difference between a waiver and a conditional waiver. The recommendation for waiver is applicable to a candidate for appointment, enlistment, or reenlistment in any status. On the other hand, a conditional waiver is considered only when an individual, *already* a member of the Naval Reserve or the Marine Corps Reserve except Fleet Reserve or Fleet Marine Corps Reserve, has been examined incident to assignment to extended active duty (other than training duty) and does not meet established physical standards.

Section XIV. DENTAL EXAMINATION AND TREATMENT

	Article
Availability of Dental Treatment	6-98
Dental Examinations	6-99
Specifications for Conducting Dental Examinations	6-100
Dental Classification of Individuals	6-101
Dental Treatment	6-102
Preventive Dentistry Programs	6-102A
Dental Prosthetic Treatment	6-103
Inscription on Dentures for Identification	6-104
Refusal of Dental Treatment	6-105
Dental Treatment by Other Than Naval Personnel	6-106

6-98. Availability of Dental Treatment

(1) At Navy and Marine Corps activities having dental treatment facilities, dental treatment shall be made available to those eligible beneficiaries designated below in accordance with BUMEDINST 6320.31 series.

(a) Members of the Navy and Marine Corps when on active duty, and Canadian Armed Forces personnel when on active duty in the United States.

(b) Members of the Fleet Reserve and the Fleet Marine Corps Reserve when on active duty.

(c) Members on the retired lists of the Navy and Marine Corps when on active duty.

(d) Members of the Naval and Marine Corps Reserve on Active Duty for Training (ACDUTRA) or performing inactive duty training (drill).

(e) Members of the Army and Air Force, provided that such members are either on active duty in localities where their own dental services are not available, or are assigned to detached duty with the Navy.

(f) Members of the Coast Guard, and commissioned corps of the Public Health Service and of the National Oceanic and Atmospheric Administration when such members are serving on active duty with the Navy under orders issued by competent authority, or are on active duty in localities where their own dental facilities are not available.

(g) Military personnel of the NATO nations on active duty who, in connection with their official duties, are stationed in or passing through the United States.

(h) Such other persons as are hospitalized in naval medical centers or hospitals, in accordance with the law.

(i) Dependents of uniformed service personnel residing outside the United States, and in areas within the United States that have been specifically designated or authorized to provide dental care for dependents, in accordance with current directives.

(j) Dependents of NATO military personnel residing in the United States with their sponsor. Dental care may be provided in naval dental facilities to the same extent and under the same conditions as comparable dependents of U.S. uniformed services personnel.

ities to the same extent and under the same conditions as comparable dependents of U.S. uniformed services personnel.

(k) Retired members of the uniformed services entitled to retired, retainer, or equivalent pay.

(l) Dependents of retired members of uniformed services personnel, entitled to retired, retainer, or equivalent pay, residing outside the United States and in areas within the United States that have been specifically authorized to provide such care, in accordance with current directives.

(m) Eligible survivors of deceased members residing outside the United States and in areas within the United States that have been specifically designated or authorized to provide dental care for dependents, in accordance with current directives.

(n) Veterans Administration patients when hospitalized in naval medical centers or hospitals.

(o) Prisoners of war.

(2) Priority in the rendering of dental treatment shall be given to members in categories (a) through (h). Dental care to other eligible and authorized beneficiaries is subject to the availability of space and facilities and the capabilities of the professional staff. When the dental officer in charge of the facility does not have sufficient space, facilities, or professional staff to provide nonemergency care to all eligible persons, nonemergency care will be furnished in the following order of priorities:

(a) Dependents of active duty members, dependents of members who died while on active duty, and dependents of NATO members on duty in the United States and residing with their sponsors (when routine dental care is authorized).

(b) Retired members of the uniformed services and their dependents and the dependents of deceased retired members (when routine dental care is authorized).

(c) Civilian employees of the Federal Government under the limited circumstances covered by the Federal Employees' Health Service Program as described in BUMEDINST 6320.31 series.

(d) All others.

(3) *Treatment of Naval and Marine Corps Reserve Members and Civilian Personnel.*—

(a) Naval and Marine Corps Reserve members, including 4-year Regular Senior and Advanced (Contract) Senior ROTC program members who, while serving on active duty for training (ACDUTRA), contract disease or otherwise become ill, are entitled to dental care to the same extent as members of the Regular service while en route to or from and during the training period. (Allowable constructive travel time is prescribed in DOD Military Pay and Allowances Entitlement Manual). Reservists performing inactive duty training (drill) are not entitled to the above en route provisions. Treatment for dental conditions that existed prior to a reservist's period of training duty is not authorized without prior approval from the commanding officer, naval regional dental center, or, for non-BUMED managed activities from BUMED (MED 04). Prosthetic appliances that have become damaged or lost during training duty, not through the negligence of the individual, may be repaired or replaced as necessary at Government expense.

(b) Dental treatment rendered to civilian personnel is authorized as limited by BUMEDINST 6320.31 series.

(1) *Within the Contiguous United States.* All appropriated—fund—activity civilian employees of the Government and Red Cross volunteers are entitled to receive all necessary dental care for work-incurred injuries or diseases proximately caused by employment, on a reimbursable basis pursuant to the United States Employees Compensation Act as administered by the Office of Workers' Compensation Programs (OWCP). Civilian nonappropriated—fund—activity employees of the Government are entitled to emergency dental care on a reimbursable basis.

(2) *Outside the Contiguous United States.* All appropriated—fund—activity civilian employees of the Government and Red Cross volunteers are entitled to care to the same extent and under the same conditions as appropriated—fund—activity civilian employees of the Government described in subparagraph (1) above. Dental care for nonappropriated—fund—activity civilian employees of the Government, full-time paid workers of the Red Cross and U.S. Navy Technicians is limited to emergencies and dental care adjunctive to inpatient hospital care, not to include dental prosthesis or orthodontics.

(4) Treatment of Veterans Administration patients shall be limited to treatment adjunctive to medical treatment of the conditions for which they are hospitalized.

(5) Treatment of persons in category (g) shall be administered only as an adjunct to inpatient hospital care and shall not include dental prosthesis or orthodontics. Adjunctive dental care is that dental care which, in the professional judgment of the attending physician and dentist, is required in the treatment or management of a medical or surgical

condition other than dental and which may be anticipated to exert a beneficial effect on the primary medical or surgical condition or its sequelae. The primary diagnosis must be specific so that the relationship between the primary condition and the requirement for dental care in the treatment of the primary condition is clearly shown. Dental care to improve the general health of the patient is not necessarily adjunctive dental care.

(6) Nothing in this article shall preclude the rendering of emergency dental treatment to any person when such treatment is necessary and demanded by the laws of humanity or the principles of international courtesy.

(7) Receipt of payment by any dental officer or enlisted person from anyone for any dental service in a naval dental activity is prohibited.

(8) The foregoing is subject to the limitations of article 6-103, which relates to dental prosthetic treatment.

6-99. Dental Examinations

(1) All dental examinations should be performed, when possible, by dental officers of the Navy or the Naval Reserve, even though the latter may not be serving on active duty. When a dental officer is not available, dental examinations of persons, other than applicants for admission to the U.S. Naval Academy as midshipmen, and candidates for flight training, may be performed by naval medical officers. (See art. 15-9(2)(a).)

(2) Dental examinations of persons in the naval service and candidates for enlistment or appointment therein shall be conducted by officers of the Dental Corps when such examinations are required by the instructions in chapter 15, section IV, and as specified below. The examining officer shall be guided in the recording of dental examinations, as well as in the use of the Dental Record, by instructions in sections XIV and XV of this chapter.

(3) Each officer of the Dental Corps shall become familiar with the contents of chapter 15, section IV, and such other portions of this manual which refer to dental examinations of naval personnel and the standards therefor. (See ch. 6, sec. XIII, and ch. 15, sec. I.)

(4) When the results of dental examinations are required to be entered on Standard Form 88, the instructions for so doing shall be followed. Care shall be taken to indicate whether or not the examinee meets the dental standards for which the examination is being done. Disqualifying dental defects shall be entered in detail.

(5) Dental examinations of all naval personnel shall be conducted annually and on other appropriate occasions to ascertain the need for dental treatment. The annual examination shall normally be a type 2 examination as described in article 6-100.

(6) When practicable, a dental examination shall be conducted for each member who reports aboard a ship or station for duty, to ascertain the need for dental treatment and to verify dental records.

(7) Dental examinations of deceased personnel for the purpose of identification shall be accomplished accurately and with as little facial disturbance as possible.

(8) The dental examination of each person who reports for, or returns to, extended active duty in the Navy or Marine Corps shall be a type 2 examination, as described in article 6-100.

(9) Naval and Marine Corps recruits shall be provided a type 2 dental examination (see 6-100) including a panoramic radiographic evaluation.

(10) Panoramic radiographs shall be retained in the Dental Folder (DD Form 722-1 or NAVMED 6322/0 thru 6322/9) as a permanent part of the Health Record. Identifying data shall include the individual's full name (surname first), social security number, and date of exposure. To orient these radiographs, a lead letter "R" shall be taped to the external surface of the X-ray cassette in such a position so as to identify, upon exposure and subsequent development, the image of the right side of the patient's dentition.

(11) Full-mouth intraoral, periapical, and posterior bitewing radiographs shall be retained in the Dental Folder (DD 722-1) or NAVMED 6322/0 thru 6322/9 Terminal Digit Jacket. Standard mounts for the serial mounting of bitewing radiographs are to be used. Cardboard serial mounts can be obtained through the Navy Supply System. Bitewing radiographs shall be mounted serially with the concave surface of the identifying "dimple" toward the observer. Indicate the date immediately below the films. Other intraoral and extraoral radiographs of specific dental conditions or sequelae of dental diseases and conditions should be retained until it is determined that their usefulness in followup examinations is no longer indicated.

(12) The dental examination of each person being separated from the Navy or Marine Corps should be a type 2 examination, as described in article 6-100, and shall be recorded on both the Standard Form 88 and 603.

6-100. Specifications for Conducting Dental Examinations

(1) The following are the specifications for conducting standard types of dental examinations:

(a) *Type 1, Ideal Examination.*—Mouth—mirror, explorer, and periodontal probe examination; adequate natural or artificial illumination; full-mouth intraoral, periapical, and posterior bitewing radiographs; when indicated, percussion, thermal, and electrical tests, transillumination, and study models.

(b) *Type 2, Routine Examination.*—Mouth—mirror, explorer, and periodontal probe examination with adequate natural or artificial illumination and when indicated, by the clinical examination, appropriate intraoral radiographs.

(c) *Type 3, Modified Routine Examination.*—Mouth—mirror and explorer examination; adequate natural or artificial illumination.

(d) *Type 4, Screening Examination.*—Mouth—mirror and explorer or tongue—depressor examination; available illumination.

(2) It shall be the professional responsibility of the dental officer to determine the type of examination which is appropriate for each patient. The dental officer shall prescribe the number and type of dental radiographs to be exposed during examination and treatment and must ensure that all current radiation safety standards are met to provide maximum shielding of individuals from radiation sources. Protective lead aprons are to be used for patients to reduce the amount of radiation received.

(3) Posterior bitewing radiographs shall be retained and mounted serially. (See article 6-99(11).)

6-101. Dental Classification of Individuals

(1) The following standard classification of individuals shall be used whenever it is necessary to classify personnel for purposes of urgency or priority of dental treatment, availability for transfer, or for determination of operational readiness of a command or unit, etc.:

(a) *Class 1.*—Individuals having no pathological oral conditions and requiring no treatment. The following are criteria for such classification:

- (1) No dental caries.
- (2) Healthy periodontium.
- (3) Slight stains—no calculus.

(4) Unerupted or partially developed teeth that are not considered to be potential causes for emergency care and are without clinical or radiographic signs or symptoms of pathosis.

(5) Edentulous spaces for which a prosthesis is not needed or planned.

(b) *Class 2.*—Individuals with minor pathological oral conditions, the treatment of which may be considered routine and not required for a period of 12 months. The following are criteria for such classification:

(1) Dental caries, not extensive or advanced.—

(a) Proximal surfaces.—Clinical and/or radiographic evidence of a carious lesion not extending beyond the dentino-enamel junction.

(b) Occlusal, facial, and lingual surfaces.—Clinical and/or radiographic evidence of a carious lesion involving the enamel only, with no extension into the dentin.

(2) Periodontal disease.—When determining the presence of periodontal disease, the term "pocket" denotes an ulcerated gingival sulcus, usually associated with bleeding and/or suppuration.

(a) Slight inflammatory signs in the gingiva, such as, red and edematous margins, gingival hyperplasia, edema, retractability blunting of the interdental papilla, bleeding upon palpation or probing, and associated with a pocket without bone loss. These signs are generally descriptive of a Type I, gingivitis case type.

(b) When the progression of gingival inflammation reaches the alveolar bone crest and early bone loss has resulted in moderate pocket formation, individuals should be considered to have early periodontitis. This case type is considered to be a Type II.

(c) Individuals with a past history of repeated episodes of periodontal therapy who are in a long term, routine maintenance phase and where the disease entity is currently under control and who would otherwise be classified as Class 3.

(3) Calculus: moderate, localized, and primarily supragingival.

(4) Edentulous areas.—Indicated prosthetic treatment for patients other than those in Class 3.

(5) Individuals who have not received those preventive dentistry treatments required on an annual basis.

(c) *Class 3.*—Individuals with pathological oral conditions for which early treatment is indicated. Any one of the following is a sufficient criterion for such classification:

(1) Dental caries, extensive or advanced.—

(a) Proximal surfaces.—Clinical and/or radiographic evidence of extensive, advanced carious lesions extending beyond the dentino-enamel junction.

(b) Occlusal, facial, and lingual surfaces.—Clinical and/or radiographic evidence of one or more carious lesions involving the dentin.

(c) Any carious lesion producing definitive symptoms.

(2) Periodontal disease.—

(a) A more advanced state of periodontal pathosis with increased destruction of periodontal structures associated with moderate to deep pockets, moderate to severe bone loss, and tooth mobility. This case type is considered to be a Type III.

(b) Further progression of periodontitis with severe destruction of the periodontal structures associated with increased tooth mobility. This case type is considered to be a Type IV.

(c) Acute gingivitis, periodontitis, or pericoronitis.

(d) Pocket depth over 5mm associated with sulcular and/or gingival hemorrhage.

(e) Any infrabony or intrabony pocket associated with periodontal pathosis and tooth mobility greater than one degree on any tooth.

(3) Calculus: excessive, widespread supra-gingival and subgingival.

(4) Acute or chronic oral infections, to include.—

(a) Periapical.

(b) Pulpal, including infections associated with incomplete endodontic therapy.

(c) Stomatal.

(5) Unerupted or malposed teeth with a history of or associated with clinical and/or radiographic evidence indicating a pathological condition.

(6) Edentulous areas.—Prosthetic treatment indicated for individuals with insufficient teeth to masticate properly, or where a prosthesis is essential to the performance of military duties, including replacement of missing anterior teeth for esthetic reasons.

(7) Patients requiring immediate emergency measures for the relief of pain, treatment of traumatic injuries, and acute oral infections.

(d) *Class 4.*—Individuals whose classification is unknown because they have not received an oral examination by a dental officer within the past 12 months or for whom no dental record exists.

(2) When recording an individual's dental classification in a record, form, or correspondence, the standard type of dental examination, as defined in article 6-100, shall also be recorded, in order that the value of the classification, as related to the comprehensiveness of the dental examination, will be apparent. Upon the completion of each patient sitting, the dental classification shall be recorded by a dental officer in the "classification" column found on the reverse side of the DD Form 603.

(3) To facilitate recognition of the four dental classifications of patients, a standard color code, utilizing a strip of appropriately colored cellophane tape shall be affixed to the Dental Folder, DD 722-1, on the backleaf over the word "Form" so that it will be readily visible when filed. If NAVMED 6322 is used as the dental record carrier jacket, the colored cellophane tape shall be affixed diagonally across the upper right hand corner of the backleaf, as described in BUMEDINST 6150.33, taking care not to cover the terminal digits with the colored cellophane tape. Colored tape shall be used to designate basic dental classifications in the following manner:

<i>Dental Class</i>	<i>Colored Tape</i>
1	white
2	green
3	yellow
4	red
	blue (see (3)(c) below)

(a) Clear cellophane tape should be placed on the dental record carrier jacket before affixing various colored tapes. This will facilitate the future placement and removal of colored tapes without tearing or damaging the carrier jacket.

(b) Dental Class 4 patients shall be identified by placing a piece of red cellophane tape over the top half of the existing dental classification tape. In this manner, the identification of the patient's previous classification is preserved.

(c) In order to readily identify those patients who require the highest priority of dental care, certain Class 2 and 3 dental patients' records may be flagged by placing a strip of blue cellophane tape over one half of the green Class 2 tape or yellow Class 3 tape. The following categories of patients should be flagged with blue tape:

(1) Patients with extensive and severe caries or periodontal disease or other pathosis requiring immediate attention, as determined by the local dental command or dental officer in charge of a dental facility or department.

(2) Personnel ordered to duty where dental care is not readily available.

(3) Personnel ordered to training billets preliminary to submarine and/or nuclear power school.

(4) Candidates for aviation and diving programs.

(5) Personnel ordered to Antarctic tours of duty or assigned to proceed to isolated or underserved areas within contiguous United States.

(6) Personnel assigned as members to a mobile medical augmentation team (MMART).

(7) Any personnel ordered to duty assignments where dental pathosis might interfere with their mission.

(d) A dental officer shall establish the patients initial classification and proper color code by conducting a Type 1 or Type 2 examination.

(e) The color coded dental classification shall be reviewed by a dental officer after each appointment and changed as needed.

(4) Each dental record carrier jacket DD 722-1 or NAVMED 6322 shall be marked with abbreviations which represent the major disciplines of dental treatment provided in the Navy. The following abbreviations will be stamped on the upper right hand corner of the frontleaf of the carrier jacket:

OPER	PERIO	O.S.	ENDO
PROS	P.D.	O.D.	

- (a) The abbreviations represent:
 OPER for Operative Dentistry
 PERIO for Periodontics
 O.S. for Oral Surgery
 ENDO for Endodontics

PROS for Prosthetics
 P.D. for Preventive Dentistry
 O.D. for Oral Diagnosis

(b) At the conclusion of each patient sitting, a dental officer shall review the treatment planning section of the Dental Health Questionnaire (NAVMED 6600/3) and blocks 5 and 16 of the SF 603 to determine the type and priority of remaining dental care. The dental officer shall use a pencil to circle the appropriate abbreviation on the front of the dental record carrier jacket for the one category of dental care most needed. The identification of the one type of dental care most needed and the color coded priority of dental care will assist independent duty Medical Department personnel to schedule dental appointments for patients under their cognizance, through fleet liaison representatives.

(c) Dental officers will erase and circle the appropriate abbreviation on the front of the dental record carrier jacket as dental care is provided and as each portion of a treatment plan is completed.

6-102. Dental Treatment

(1) Dental treatment may be rendered only by dental officers, with the following exceptions:

(a) Oral prophylaxes and preventive dentistry applications of cariostatic agents may be administered by dental technicians and civilian dental hygienists under the supervision of a dental officer.

(b) When a dental officer is not available, emergency dental treatment may be administered by dental technicians or by personnel of the medical department. Dental officers standing watches are considered to be available.

(2) Orthodontic treatment may be provided for active duty Navy and Marine Corps personnel and their dependents at those naval dental facilities having an established orthodontic capability approved by the Bureau of Medicine and Surgery. Detailed guidelines for rendering orthodontic care are found in BUMEDINST 6670.1 series to provide:

(a) Orthodontic treatment for active duty personnel, if assignment, rotational, or separation problems are neither involved nor anticipated. Additional criteria to be considered when evaluating active duty personnel for orthodontic treatment should include:

(1) The correction has been determined as beneficial to the individual's health and performance of duty;

(2) The individual has sufficient active service obligation remaining and sufficient time remaining in the present tour of duty to allow completion of treatment at the present duty location; and

(3) No alternative corrective therapy is acceptable.

(b) The initiation and continuation of active orthodontic treatment for command-sponsored

dependents of active duty personnel who relocate to reside with their sponsors on active duty in an area where dependent dental care is authorized.

(3) Elective orthodontic care for active duty personnel may be obtained from non-Federal sources at no expense to the Government. The guidelines pertaining to elective orthodontic care as outlined in BUMEDINST 6670.1 series apply to orthodontic care for active duty personnel received from non-Federal sources. If a patient should be reassigned to a location where orthodontic care is unavailable, termination of treatment may be necessary before the orthodontic care is completed. If this should occur, the Government is not liable for the completion of orthodontic treatment. Dental care, such as the extraction of teeth, adjunctive to the providing of elective orthodontic treatment by non-Federal orthodontists may be obtained from Navy dental facilities. The providing of adjunctive care by the Navy does not imply liability in the completion of the elective orthodontic care.

(4) Treatment of dental diseases, disabilities, and injuries of Navy and Marine Corps personnel shall be completed whenever possible. When it is not possible to complete all treatment, priority shall be given, as reflected in 6-101, to treating those conditions which are most likely to interfere with the performance of duties.

(5) Priority for dental treatment within each classification in article 6-101 and for preventive dentistry treatment in article 6-102A shall be given to fleet units and those personnel deployed or assigned to areas where dental support is other than maximum.

(6) The dental officer shall notify the medical officer when diseases or other conditions requiring medical care or consultation are observed.

(7) Whenever, in the opinion of the dental officer, it is necessary to place dental patients on the binnacle list or sicklist, the medical officer shall be notified in order that the entries in the Health Record may be made in accordance with chapter 16, section IX.

(8) The care of a patient admitted to the sicklist because of dental, oral, and/or related disabilities shall be the responsibility of the dental officer treating the patient and other appropriate members of the Medical Department as dictated by current directives.

(9) Dental care providers should take positive steps to query patients as to their status in the Personnel Reliability Program (PRP). Personnel, such as those associated with the Nuclear Weapons Personnel Reliability Programs, are identified in BUPERSINST 5510.11 series. Querying should take place when completing health history forms, at time of treatment, or whenever deemed appropriate. NAVPERS 5510/1, Record Identifier for Personnel Reliability Program, shall be filed in each dental record of PRP personnel when the medical and

dental health records are maintained separately. Whenever health care treatment forms related to dental care are temporarily separated from the dental treatment record to procure consultations or to provide treatment, a NAVPERS 5510/1 shall accompany the form(s). If patients in the PRP are provided medications associated with dental treatment that could affect performance of duties, their immediate command should be notified by telephone or the most rapid means of communication available. Backup notification utilizing the Standard Form 600 or DD Form 689, as appropriate, should be expeditiously processed and forwarded to the custodian of the patient's medical records.

(10) Grounding Notices

(a) Officers of the Dental Corps are authorized to issue Grounding Notice (Aero-Medical) NAVMED 6410/1 in any instance where dental evaluation or treatment has been performed on an aviation rated service member when such procedure could be considered detrimental to the performance of aviation duty, or when any untreated dental condition is considered of such severity as to preclude safe aviation performance. To assist dental personnel in handling these notices and to expedite subsequent clearance procedures, dental patients will be divided into two general categories according to the nature of the dental procedures performed. The grounding notices will be completed differently for each group:

(1) *Group A.*—Personnel undergoing simple procedures utilizing local infiltration and/or blocking anesthetics, e.g., restorations, etc. The attending dental officer will issue an automatically expiring grounding notice for a period of 24 hours from the time procedure was completed. Personnel may be cleared for aviation duty sooner than 24 hours on the approval of the flight surgeon.

(2) *Group B.*—For personnel undergoing any of the following procedures, the attending dental officer will issue a nonexpiring 72-hour grounding notice. The patient should be instructed to return to the aviation medicine department no more than 72 hours from the day of issue of the grounding notice. Fitness for flight duty will be determined by the flight surgeon, who may consult with the dental officer as necessary.

(a) Extractions.

(b) Incision and drainage.

(c) All oral surgical procedures including periodontal surgery involving suturing and dressing placement.

(d) Administration of intravenous or inhalation sedative or analgesic/anesthetic agents.

(e) Root canal resulting from acute pain, abscess, or other cause if the patient is symptomatic or the canal is open.

(f) Prescription of any medication, except prophylactic antibiotics used for pre-existing condition.

(b) General procedures for completing the NAVMED 6410/1, Grounding Notice.—

(1) The personal data portion should be completed by following the instructions in the individual blanks. If preferred, the airman's personal data may be completed by stamping in the upper left portion of the form with the plastic medical card. The originator and the addressee should be plainly marked.

(2) Section C., Block "Other", should contain a short description of the procedure performed and the reason for grounding, e.g., "local anesthetic", "extraction using anesthetic gas", "narcotic medications prescribed", etc.

(3) Estimated duration of grounding will be "24 hours" or "72 hours" as applicable.

(4) On line "3" include one of the following statements as applicable from the preceding guidelines:

(a) "Expires automatically. Clearance Notice not required."

(b) "Nonexpiring. Clearance required from flight surgeon prior to resuming flight duties."

(5) The notice should carry the signature of the attending dental officer.

(6) Complete three copies and distribute as follows:

- 1 — To patient for delivery to patient's command.
- 1 — By guard mail to patient's command.
- 1 — To aviation medicine at end of each working day.

(c) No portion of this agreement should preclude direct communication between the dental officer and the flight surgeon if any question, whatsoever, should arise concerning proper management of a dental patient.

6-102A. Preventive Dentistry Programs

(1) *Establishment.*—All dental activities shall have a preventive dentistry program in accordance with SECNAVINST 6600.1 series which shall, as a minimum, consist of:

(a) An annual dental examination in accordance with article 6-99(5).

(b) A self-preparation or professionally applied stannous fluoride prophylaxis in conjunction with a topical stannous fluoride treatment annually and prior to deployment or transfer to activities, or areas, where dental support is other than maximum.

(c) Oral health education instructions given through individual or small group sessions. These sessions shall include, as a minimum:

(1) Education regarding the relationship between plaque, diet, caries, and periodontal disease.

(2) Demonstration of interproximal plaque removal techniques.

(3) Demonstration of sulcular methods of tooth cleansing with a toothbrush.

(4) Instruction in the use of plaque disclosing media.

(d) The adjustment of fluoride content of water supplies at military installations shall be as follows:

(1) Dental activities located ashore shall determine the source of the base water supply and its fluoride content, in accordance with OPNAVINST 11330.1 series.

(a) If the water supply has been adjusted to contain optimum fluoride levels, frequent reports on the fluoride level shall be obtained.

(b) If the water supply is fluoride deficient or contains higher than optimum fluoride levels, efforts shall be directed toward proper adjustment where feasible.

(2) When adjustment of the fluoride content of the home water supplies is not feasible, prescriptions for suitable systemic fluoride supplements shall be offered to parents for use by children under 17 years of age.

(e) *Mouth Guards.*—All dental activities with limited or full prosthetic capabilities shall offer to provide protective mouthpieces for all active duty personnel engaged in sports involving body contact.

(2) *Dependents.*—A dependent preventive dentistry program may be established in accordance with SECNAVINST's 6320.8 and 6000.3 series. Enclosure (1) to SECNAVINST 6600.1 series provides guidelines for dependent dental care at military facilities. Additional dental treatment shall not be performed in connection with this program unless the patient is eligible under article 6-98(1)(i). The program may consist of:

(a) A self-preparation or professionally applied fluoride prophylaxis in conjunction with a topical fluoride treatment.

(b) Oral health education and demonstration.

(c) Dietary counseling.

(d) Community or school based oral health education programs in DOD communities.

(e) Optimizing the fluoride content of water supplies.

(f) Use of occlusal sealants for dependent children where eligible under article 6-98(1)(i).

(g) Providing protective mouthpieces for all dependents engaged in sports involving body contact.

(h) Prenatal dental counseling.

(3) *Periodontal Disease Control.*—The Navy Periodontal Disease Index, Part I of form NAVMED 6600/4, may be performed as appropriate for oral health care education and, if performed, shall be recorded in the SF 603 (art. 6-118). The completed form shall be maintained in the Dental Folder DD 722-1 or NAVMED 6322/0 thru 6322/9 as part of the dental record until completion of treatment.

(4) *Plaque Control.*—The Navy Plaque Index, Part II of form NAVMED 6600/4, may be performed as

appropriate for oral health care education and shall be recorded in the SF 603 (art. 6-118). The completed form may be maintained in the Dental Folder, DD 722-1, as part of the dental record until completion of the treatment.

(5) *Preventive Dentistry Officer.*—A dental officer shall be appointed as the preventive dentistry officer at each dental command, dental service, dental department, or dental company to which more than one dental officer is assigned. Where only one dental officer is assigned, that officer shall serve as the preventive dentistry officer. The preventive dentistry officer shall be responsible for the formulation, supervision, and execution of all aspects of the preventive dentistry programs.

(6) *Consultation and Evaluation.*—Dental officers with advanced training in preventive dentistry, wherever assigned, shall be available for consultation regarding establishment of preventive dentistry programs and for evaluation of existing programs.

6-103. Dental Prosthetic Treatment

(1) Except for minor repairs or adjustments, dental prosthetic treatment, which includes the fabrication of crowns, inlays, fixed partial dentures, and dentures shall be furnished only at activities authorized by the Bureau to provide such treatment.

(2) Dental prosthetic treatment is furnished to Veterans Administration patients hospitalized in naval medical centers or hospitals when such treatment is clearly adjunctive to the medical treatment for which the veteran is hospitalized.

(3) Dental officers on duty at activities where no prosthetic facilities are available shall ensure that all oral surgical and operative treatment has been completed on personnel being referred to other commands for prosthetic treatment.

6-104. Inscription on Dentures for Identification

(1) Each dental prosthetic facility shall, when possible, incorporate into the denture base or other

suitable part of each complete or partial denture, the following data pertaining to the patient.

(a) Social security number (SSN), followed by a dash and capital N for Navy, M for Marine Corps, A for Army, and AF for Air Force, whichever applies.

(b) When space considerations do not permit the application of the complete SSN, the last four digits may be used.

(c) No other information shall be inscribed.

(2) A stainless steel insert, .001 inch thick, is the material of choice for use of identification. Alternative materials may be used where the use of stainless steel may interfere with fabrication of the prosthesis. The inscription shall be typed on the insert material and inserted in the denture base so that the inscription is legible.

6-105. Refusal of Dental Treatment

(1) Members of the naval service who refuse to submit to recommended dental treatment considered necessary to keep them fit to perform their duties shall be processed in accordance with article 18-15. Such disposition shall not be made, however, until after a conscientious effort has been made by the dental officer to convince the member of the value of the proposed treatment in preserving or achieving dental health. An appropriate entry regarding the refusal of treatment shall be made in the SF 603, in accordance with article 6-112.

6-106. Dental Treatment by Other Than Naval Personnel

(1) Dental treatment (including prosthetic treatment) may also be obtained from Army and Air Force and other Federal facilities and at civilian sources in accordance with the BUMEDINST 6320.32 series.

Section XV. THE DENTAL RECORD AND OTHER STANDARD FORMS

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6-107. Purpose of Standard Form 603

- (1) The SF 603 provides:
 - (a) Aid to diagnosis, treatment planning, and practice management.
 - (b) Valuable means of identification.
 - (c) Record of the initial examination of a member which shows missing teeth, existing restorations, diseases, and other abnormalities.
 - (d) Record of diseases and other abnormalities which occur after the initial examination.
 - (e) Chronological record of dental treatment received during the individual's period of military service.
 - (f) Protection to the Government against false or fraudulent claims and a protection of veteran benefits for the individual.
 - (g) Basis for dental statistical information.
 - (h) Means for facilitating the appraisal of physical fitness and the dental health profile.

6-108. Preparation, Distribution, and Disposition of Standard Form 603

- (1) *Preparation.*—An original shall be prepared:
 - (a) For each individual who reports for, or returns to, extended active duty.
 - (b) To replace a lost SF 603.
 - (c) At the time the initial examination or dental treatment is provided to a dependent (see art. 6-98(1)(i)). Boxes 1 through 4 of section I need not be completed. Boxes 8 through 11 of section II should reflect the name and information on the dependent's sponsor. The sponsor's military service number and social security number shall be placed in box 14 of section II.
- (2) *Distribution.*—
 - (a) The original prepared at recruit training centers for recruits shall be placed in the DD 722-1

(Dental Folder) or NAVMED 6322 after the original examination. Entries for dental treatment accomplished for a recruit during the recruit training period shall be made on the original. The original is to remain in the DD 722-1 or NAVMED 6322.

(b) For persons, other than recruits, who report for or return to extended active duty, the original is to remain in the DD 722-1 or NAVMED 6322.

(c) Only an original SF 603 shall be prepared when dental records are lost or destroyed and shall be placed in the DD 722-1 or NAVMED 6322; it shall be prominently marked "REPLACEMENT."

(d) One DD 722-1 or NAVMED 6322 shall be prepared to enclose all SF 603's established for the dependents of each sponsor. For the DD 722-1, the sponsor's name shall be typed in the name block and DEPENDENT shall be typed in the service number block. Where pedodontic care is authorized, a commercially available pedodontic dental chart may be attached to the dependent SF 603. For uniformity, the pedodontic chart should use the numerical-letter system for tooth identification, which consists of 1 through 32 for permanent teeth and A through T for primary teeth. A separate file, arranged alphabetically, shall be maintained for dental records of dependents.

(3) *Disposition.*—

(a) The SF 603 shall accompany Navy and Marine Corps personnel from activity to activity during their entire period of military service. The dental officer shall assure that the Dental Folder (DD 722-1 or NAVMED 6322) with the SF 603, current periapical and bite-wing X-rays, and other pertinent records are forwarded to the medical officer for inclusion in the Health Record whenever an individual is transferred.

(b) When personnel are transferred, the medical officer or medical department representative shall

see that the current Dental Record (SF 603), enclosed in a dental carrier jacket, is included before the Health Record is transferred. (see art. 16-20).

(c) The SF 603 of a dependent shall not be included in the medical Clinical Record of the dependent at the time the dependent is transferred from the area of the facility providing dental treatment.

(d) The SF 603 of a dependent shall not be included in or transferred with the sponsor's record at the time of transfer or change of duty stations.

(e) All dependent's SF 603's and roentgenograms shall be disposed of in accordance with the disposal instructions in paragraph 6600(2)(b) of SECNAVINST 5212.5 series.

(f) Dependent Dental Records may be released to military dependents requesting them upon transfer, in accordance with the guidelines promulgated in BUMEDINST 6150.1 series. Custody of records may be transferred to military sponsors, their spouses, or other authorized adult dependents. Additionally, records may, upon request, be sent by mail to the sponsor, spouse, station dental facility, or regional dental center responsible for continuation of treatment. Actual release of custody of records should be in strict accordance with form NAVMED 6150/8, Outpatient Record Release Request and Transfer Receipt.

(4) *Entries.*—Details regarding entries on the SF 603 are as follows:

(a) *SECTION I, DENTAL EXAMINATION.*—

Box 1, PURPOSE OF EXAMINATION.—

An X shall be placed in the appropriate space. In the space OTHER (specify), indicate "Naval Academy," "Reenlistment," "Fleet Reserve," etc.

Box 2, TYPE OF EXAMINATION.—The type of examination as listed in article 6-100 shall be indicated by an X in the appropriate space.

Box 3, DENTAL CLASSIFICATION.—

The dental classification as listed in article 6-101 shall be indicated by an X in the appropriate space.

Box 4, MISSING TEETH AND EXISTING RESTORATIONS.—The dental chart shall be

completed in accordance with article 6-117. Entries shall not be altered after the initial examination except that at recruit training centers, corrections may be made through the period of recruit training. If the individual is appointed or enlisted with dental defects which have been waived, the defects should be described fully under REMARKS. The notation of existing fixed passive orthodontic appliances is also made under REMARKS.

Box 5, DISEASES, ABNORMALITIES, AND X-RAYS.—The dental chart shall be completed in accordance with article 6-117. The appropriate data shall be placed in the other spaces in this box.

(b) *SECTION II, PATIENT DATA.*—Appropriate data shall be placed in boxes 6, 7, 8, 11 (USN, USMC, etc.), 12, 13, and 14. Boxes 9 and 10 apply to examinations performed for Army and Air Force

personnel. Entries in box 8 shall be made in pencil and corrected, when appropriate to reflect the current grade or rate of the patient.

(c) *SECTION III, ATTENDANCE RECORD.*—

Box 15, RESTORATIONS AND TREATMENT (Computed during service).—Markings appropriate to the dental treatment received shall be placed on the dental chart in accordance with the provisions of article 6-117.

Box 16, SUBSEQUENT DISEASES AND ABNORMALITIES.—The chart shall be used to record dental defects and diseases found during subsequent examinations. Entries shall be made in pencil and erased when treatment is accomplished or when the condition no longer exists.

Box 17, SERVICES RENDERED.—Entries shall be made in the columns designated DATE, DIAGNOSIS—TREATMENT CLASS, and OPERATOR AND DENTAL FACILITY, as illustrated in article 6-118. The column CLASS shall conform with article 6-101 and be maintained up-to-date as the work progresses. The column OPERATOR AND DENTAL FACILITY shall contain the signature of the operator and the name of the activity to which attached.

(d) *PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME.*—The space provided in the lower right margin on the reverse of the SF 603 is for the patient's name as a convenience for filing. The last name shall be in CAPITALS, and no part of the name shall be abbreviated. The social security number shall be used for IDENTIFICATION NO.

(e) When an enlisted person is advanced to commissioned or warrant grade, reenlists, or extends an enlistment; or upon promotion of an officer or commissioning of a midshipman; the SF 603 shall be brought up-to-date by entering any unrecorded dental treatments on the chart in box 15 and any dental defects or diseases on the chart in box 16.

6-109. Dental Folder, DD Form 722-1 and NAVMED 6322/0 through 6322/9

(1) A Dental Folder (DD Form 722-1 or NAVMED 6322/0 through 6322/9) shall be prepared for each individual on active duty in the Navy or Marine Corps (see art. 16-29). The Dental Folder shall contain the SF 603 and other information pertinent to the dental health of the individual. The contents of the folder shall be assembled in the following manner:

(a) On right side in top to bottom sequence:

(1) Record Identifier for Personnel Reliability Program, NAVPERS 5510/1, when appropriate.

(2) Health Record—Dental, SF 603.

(3) Doctor's Progress Notes, SF 509; Narrative Summary, SF 502; and Tissue Examination, SF 515.

(4) Consultation Sheet, SF 513, (when related to dental treatment).

(5) Navy Periodontal Screening Exam, NAVMED 6600/4 (when retained).

(b) On left side in top to bottom sequence:

(1) Unmounted radiographs in envelopes.

(2) Sequential bitewing radiograph mounts.

(3) Panoramic and/or full mouth radiographs.

(4) Dental Health Questionnaire, NAVMED 6600/3.

(5) Privacy Act Statement, DD Form 2005.

(2) When an individual is attached to a ship or station having a dental facility, the Dental Folder shall be placed in the custody of, and shall be the responsibility of, the dental officer. The individual's current duty station shall be entered in the designated space on the Dental Folder in order to facilitate the return of a lost or misplaced dental record. When practicable, verification of the Dental Record shall be conducted in conjunction with that of the Health Record, Service Record, and Pay Record. Otherwise, verification should be accomplished upon reporting, at the time of physical examination, and upon detachment. (See arts. 16-3 and 16-18(3).) An initialed entry to the effect that the verification has been accomplished shall be recorded in the designated space on the Dental Folder. For an individual who has been transferred without a dental record, every effort shall be made to determine the present duty station, status, or location, and, if determined, the record shall be forwarded. If these efforts fail to determine a member's duty station, only then should activities request assistance from BUMED. Activities shall include in their request a list containing the following information for each record/form held: the member's name, grade, SSN, last known duty station, and a description of the records/forms. The records/forms shall be retained by the activity and the list shall be forwarded to BUMED (MED 3111). Under no circumstances shall records/forms be forwarded to BUMED.

(3) When an individual is attached to a ship or station to which no dental officer is attached, or is in transit, or is ordered to appear before a board necessitating a physical examination, the Dental Folder shall remain with the Health Record, DD Form 722.

(4) The contents of the Dental Folder shall be removed and placed with the medical records in the Health Record Jacket only when the Health Record is being closed. After this is accomplished the Dental Folder shall be destroyed.

(5) Replace the Dental Folder when it has been damaged or becomes illegible because of deterioration.

6-110. Custody of Standard Form 603

(1) Custody of the SF 603 shall be the same as that described for the Dental Folder in articles 6-109(2), (3), and (4).

(2) Custody of the SF 603 prepared for retired personnel not on active duty shall be the responsibility of the individual.

(3) For details regarding the Health Record Jacket, DD Form 722, and the Health Record, see chapter 16.

6-111. Recovery of Lost Standard Form 603

(1) Upon recovery of a lost SF 603, entries shall be made in the recovered record of any data recorded in a replacement record, and the replacement record shall be destroyed.

6-112. Special Entries in Standard Form 603

(1) When dental treatment is refused by the patient, appropriate entries shall be made in the SF 603 and signed by the dental officer.

(2) In situations involving dental injuries or disease incurred due to the person's own misconduct, or not in line of duty, a notation to that effect shall be made in the SF 603 and signed by the dental officer. The commanding officer and the person concerned shall be informed in writing whenever such an entry is made in the person's dental record. (See NAVREGS 1111.2.)

(3) Suitable entries shall be made in the SF 603 whenever a member of the Navy or Marine Corps returns from a medical center, hospital, or station, other than the permanent duty station, where dental treatment has been received but not recorded. Likewise, entries shall be made when it is learned that treatment has been received from civilian sources.

(4) If it is determined that an individual is hypersensitive to a local anesthetic or any other substance, or has valvular or congenital heart disease, a statement to that effect shall be entered in red pencil across the top of the SF 603 and on the outside of the DD 722-1 or NAVMED 6322. Hypersensitivity to a drug or chemical shall also be recorded on the SF 601 and the SF 600 which is retained in the Health Record. Examples: HYPERSENSITIVE TO PROCAINE. MITRAL STENOSIS.

(5) The dental officer shall inform the person concerned whenever an entry is made in that person's Dental Record which may adversely affect, in other than a temporary degree, that person's efficiency in the performance of duty. (See NAVREGS 1111.1.)

6-113. Recording Dental Examinations

(1) It is very important that the charted record of dental examinations be in exact conformity with the

provisions set forth in articles 6-115 through 6-117 and unquestionably accurate. The Veterans Administration depends upon the SF 603 for accurate data when adjudicating the claim of a veteran for a service-connected dental disability. The SF 603 is extremely valuable when other means of identification fail.

(2) Any peculiarities or deviations from normal are particularly valuable for identification purposes and should be recorded under REMARKS. Such abnormalities as erosion, abrasion, mottled enamel, hypoplasia, rotation, irregularity of alignment and malocclusion of teeth, denticles, Hutchinson's teeth, fractures of enamel or teeth, abnormal interdental spaces, mucosal pigmentation, leukoplakia, diastema, hypertrophied frenum labium, torus palatinus and torus mandibularis, embedded foreign bodies, and descriptions of unusual restorations or appliances are, when noted, especially useful in this connection. Malocclusion should be simply and clearly described. Dentures and other removable dental appliances also should be described under REMARKS.

(3) When all teeth present are free of caries and restorations, special effort shall be made to discover and record any abnormalities, however slight. If no caries, restorations, or abnormalities are found, an entry to that effect shall be made under REMARKS.

6-114. Recording Dental Operations and Treatments

(1) All dental restorations shall be charted on the dental chart in section III of SF 603 in accordance with the instructions set forth in article 6-117 and illustrated in article 6-118. When the spaces in section III of the SF 603 have been filled by the recording of dental operations and treatments, the SF 603A (Dental-Continuation) shall be used for additional entries.

(2) Authorized abbreviations covering the operations and treatments shall be entered in section III in the spaces under SERVICES RENDERED. Such entries shall be complete, accurate, and brief, in accordance with the provisions of articles 6-115 through 6-118.

6-115. Designations and Abbreviations for Use on Standard Form 603

(1) For purposes of brevity and exactness, the following numerical designation of teeth shall be used in keeping the SF 603:

<i>Tooth</i>	<i>Designation</i>
Right maxillary third molar	1
Right maxillary second molar	2
Right maxillary first molar	3
Right maxillary second bicuspid	4
Right maxillary first bicuspid	5

<i>Tooth</i>	<i>Designation</i>
Right maxillary cuspid	6
Right maxillary lateral incisor	7
Right maxillary central incisor	8
Left maxillary central incisor	9
Left maxillary lateral incisor	10
Left maxillary cuspid	11
Left maxillary first bicuspid	12
Left maxillary second bicuspid	13
Left maxillary first molar	14
Left maxillary second molar	15
Left maxillary third molar	16
Left mandibular third molar	17
Left mandibular second molar	18
Left mandibular first molar	19
Left mandibular second bicuspid	20
Left mandibular first bicuspid	21
Left mandibular cuspid	22
Left mandibular lateral incisor	23
Left mandibular central incisor	24
Right mandibular central incisor	25
Right mandibular lateral incisor	26
Right mandibular cuspid	27
Right mandibular first bicuspid	28
Right mandibular second bicuspid	29
Right mandibular first molar	30
Right mandibular second molar	31
Right mandibular third molar	32

(2) A deciduous tooth shall be indicated by placing a "D" around a specific tooth number. If both permanent and deciduous teeth are present, place a "D" in location of the deciduous tooth and enter the appropriate tooth number inside the "D".

(3) The following designation of tooth surfaces shall be used in connection with recording restorations of defective teeth:

<i>Surface</i>	<i>Designation</i>
Facial (labial and buccal)	F
Lingual	L
Occlusal	O
Mesial	M
Distal	D
Incisal	I

(4) Combinations of the designations shall be used to identify and locate caries, operations, or restorations in the teeth involved; for example, 8-MID would refer to the mesial, incisal, and distal aspects of a right maxillary central incisor; 22-DF, the facial and distal aspects of a left mandibular cuspid; 3-MODF, the mesial, occlusal, distal, and facial aspects of a right mandibular first molar.

(5) The use of abbreviations and acronyms is not mandatory but it is desirable in view of the limited space available in the SF 603 for recording treatment

rendered. In addition to the following authorized abbreviations, well known medical, dental, and scientific signs and symbols such as Rx, &cc, &ss, and H₂O₂ may be used in recording dental treatment.

Abscess	Abs.
All Caries Not Removed	ACNR
All Caries Removed	ACR
Alveolectomy	Alvy.
Amalgam	Am.
Anesthetic (thesia)	Anes.
Apicoectomy	Apcy.
Base	B
Camphorated paramonochlorophenol	CMCP
Cement	Cem.
Complete Denture	CD
Crown	Cr.
Curettage	Cur.
Drain	Drn.
Dressing	Drs.
Equilibrate (ation)	Equil.
Eugenol	Eug.
Examination	Exam.
Extraction (ed)	Ext.
Fixed Partial Denture (bridge)	FPD
Fracture	Fx.
Gingivitis	Gvtis.
Gutta Percha	GP
Mandibular	Man.
Maxillary	Max.
Navy Periodontal Disease Index	NPDI
Navy Plaque Index	NPI
Necrotizing Ulcerative Gingivitis	NUG
Pericoronitis	Pecor.
Periodontitis	Pdtis.
Plaque Control Instructions	PCI
Point(s)	Pt(s).
Porcelain	Porc.
Post Operative Treatment	POT
Prophylaxis	Pro.
Reline	Rel.
Removable Partial Denture	RPD
Repair (ed)	Rep.
Root Canal Filling	RCF
Root Canal Therapy	RCT
Scaled (ing)	Sci.
Self Preparation	SP
Silicate	Sil.
Surgical	Surg.
Suture(s) (d)	Su.
Temporary	Temp.
Treatment (ed)	Tr.
Varnish	Varn.

6-116. General Characteristics of Markings on Dental Charts

(1) Chart markings have been standardized so that the original dental condition, treatment needed, and treatments completed may be readily identified. This

facilitates efficient continuity of treatments and may establish identification in certain circumstances.

(2) Dental recordings shall be made in black or blue-black ink on all charts of the SF 603, except that entries on the chart in box 16 shall be made in pencil.

6-117. Differential Characteristics of Markings on Dental Charts

(1) Markings shall be made on examination chart MISSING TEETH AND EXISTING RESTORATIONS as follows:

(a) *Missing Teeth*.—Draw a large "X" on the root or roots of teeth not visible in the mouth.

(b) *Edentulous Mouth*.—Inscribe crossing lines, one extending from the maxillary right third molar to the mandibular left third molar and the other from the maxillary left third molar to the mandibular right third molar.

(c) *Edentulous Arch*.—Make crossing lines each running from the uppermost aspect of one third molar to the lowermost aspect of the third molar on the opposite side.

(d) *Amalgam Restorations*.—In the diagram of the tooth, draw an outline of the restoration showing size, location, and shape, and block in solidly.

(e) *Nonmetallic Permanent Restorations (Includes Filled and Unfilled Resins)*.—In the diagram of the tooth, draw an outline of the restorations showing size, location, and shape.

(f) *Gold Restorations*.—Outline and inscribe horizontal lines within the outline. If made of an alloy other than gold, the same applies, except indicate in the REMARKS section that the crown is made of a metal other than gold. Indicate where possible, the type of alloy used.

(g) *Combination Restorations*.—Outline, showing overall size, location, and shape; partition at junction of materials used and indicate each as in (d) and (e) above.

(h) *Porcelain Facings and Pontics*.—Outline each aspect. Indicate in the REMARKS section that the facing or pontic is made of porcelain.

(i) *Acrylic Resin Facings and Pontics*.—Outline and indicate acrylic in the REMARKS section.

(j) *Porcelain Post Crowns*.—Outline each aspect of the crown; outline approximate size and position of the post or posts. Indicate porcelain material in REMARKS section.

(k) *Acrylic Resin Post Crowns*.—Outline each aspect of the crown; outline approximate size and position of the post or posts. Indicate acrylic material in REMARKS section.

(l) *Porcelain Jacket Crowns*.—Outline each aspect. Indicate porcelain material in REMARKS section.

(m) *Acrylic Resin Jacket Crowns*.—Outline each aspect. Indicate acrylic material in REMARKS section.

(n) *Fixed Partial Dentures (Bridges).*—Outline each aspect showing overall size, shape, location, and teeth involved. Partitioning should be designated at the junction of materials. Gold shall be shown by the inscription of diagonal lines instead of horizontal lines for both abutments and pontics. If constructed of a metal other than gold, the same applies except an indication should be made in the REMARKS section that the fixed partial denture is made of an alloy other than gold. Indicate, where possible, the type of alloy used. Facing materials should be indicated in REMARKS section.

(o) *Removable Appliances.*—Place a line over numbers of replaced teeth and describe briefly in REMARKS.

(p) *Root Canal Fillings.*—Outline each canal filled on the diagram of the root or roots of the tooth involved and block it in solidly.

(q) *Apicoectomy.*—Draw a small triangle on the root of the tooth involved, apex away from the crown, the base line to show the approximate level of root amputation.

(r) *Drifted Teeth.*—Draw an arrow from the designating number to the tooth that has moved, the point of the arrow to indicate the approximate position to which it has drifted. Under REMARKS note the relationship of the drifted tooth in respect to occlusion.

(2) Markings on examination chart, Section I(5), DISEASES, ABNORMALITIES, AND X-RAYS shall be made as follows:

(a) *Caries.*—In the diagram of the tooth affected, draw an outline of the carious portion, showing size, location, and shape, and block in solidly.

(b) *Defective Restoration.*—Outline and block in solidly the restoration involved.

(c) *Impacted Teeth.*—Outline all aspects of each impacted tooth with a single oval. The long axis of the tooth should be indicated by an arrow pointing in the direction of the crown.

(d) *Abscess.*—Outline approximate size, form, and location.

(e) *Cyst.*—Outline the approximate form and size in relative position on the dental chart.

(f) *Periodontitis.*—A clinical assessment of each individual's periodontal requirements should be accomplished to facilitate classification as a Type I, II, III, or IV Periodontal Case. Criteria for periodontal case typing is found in 6-101(1)(a), (b), and (c). Initial periodontal classifications should be recorded in ink on the front of SF 603, section I, block 5, beneath the ABNORMALITIES OF OCCLUSION—REMARKS line. Subsequent periodontal case typing should be recorded and dated in pencil on the back of SF 603 or an SF 603-A in the REMARKS section of block 16. No entries are necessary in the absence of periodontal pathosis.

(g) *Tooth Extraction Needed.*—Draw two parallel vertical lines through all aspects of each tooth involved.

(h) *Fractured Tooth Root.*—Indicate fracture with a zigzag line on outline of tooth root.

(3) Markings on the chart RESTORATIONS AND TREATMENTS shall be made as follows:

(a) *Carious Teeth Restored.*—In the diagram of the tooth involved, draw an outline of the restoration showing size, location, and shape, and indicate material used as specified in subarticle 6-117(1); that is, amalgam restorations would be outlined and blocked in, silicate cement restorations outlined only, etc. When a temporary restoration is placed, either ACR or ACNR should also be recorded.

(b) *Extractions.*—Draw a large "X" on the root or roots of each tooth extracted.

(c) *Root Canal Fillings.*—Outline each canal filled on the diagram of the root or roots of the tooth involved and block in solidly.

(d) *Apicoectomy.*—Draw a small triangle on the root of the tooth involved, apex away from the crown, the base line to show the approximate level of root amputation.

(e) *Fixed Partial Dentures and Crowns.*—Outline and fill in as specified in subarticle 6-117(1). If made of chrome alloy or a portion of the unit is constructed of acrylic or porcelain, it should be so indicated in the REMARKS section.

(f) *Removable Appliances.*—Place a line over numbers of replaced teeth and give a brief description under REMARKS. When a prosthodontic appliance has been fabricated (in part or entirely) by another activity, the name of the laboratory shall be recorded immediately after the record of insertion. Examples:

(1) 2, 4, 5, 7, 12, & 14—Max. RPD.—Titanium frame fabricated by Naval Regional Dental Center, Norfolk, VA.

(2) Max. & Man. CD.—Case fabricated by U.S.A. Area Prosthetic Laboratory, Alameda, CA.

(g) *Unrecorded Operations and Conditions.*—Operations performed by other than naval dental officers subsequent to the original examinations shall be indicated by the dental officer discovering the condition just as if they had been done by a naval dental officer. Appropriate entries shall be made indicating the nature of the treatment and adding the abbreviation "Civ." or other abbreviation as appropriate. The date entered shall be the date of discovery. Operations known to have been performed by naval dental officers whose identity is not recorded shall be noted similarly except that the abbreviation "NDO" shall be used. The date entered shall be the date the operation is discovered. Teeth which are shown as missing in the chart MISSING TEETH AND EXISTING RESTORATIONS and which have erupted subsequently shall be accounted for by an entry in the following manner: "1, 32, eruption

noted," with date and signature of dental officer making the notation. Other conditions of comparable importance should be recorded in a similar manner.

(4) Markings on the chart SUBSEQUENT DISEASES AND ABNORMALITIES shall be as indicated for the chart DISEASES, ABNORMALITIES, AND X-RAYS.

6-118. Illustrations of Markings on Dental Charts

- (1) See illustrations on the following three pages.

6-119. Recording of Dental Treatment on Chronological Record of Medical Care, Standard Form 600

(1) Entries of dental treatment shall be made on the SF 600 when the patient is on the sicklist, and when treatment is related to the condition for which the patient is admitted. Such entries shall be made and signed by the dental officer. Notes concerning conditions of unusual interest and of medical or

dental significance may be made when appropriate. An abbreviated summary of all dentally related medical care and dental treatment shall be entered in block 17 of SF 603.

6-120. Consultation Sheet, Standard Form 513

(1) The SF 513 may be used by dental officers requesting a medical consultation pertaining to a dental patient. The SF 513 is to be included in the patient's dental record carrier jacket, DD 722-1 or NAVMED 6322.

6-121. Doctor's Progress Notes, Standard Form 509

(1) The SF 509 may be used by dental officers for posting information on the progress made by a patient during hospitalization. This form is to be included in the patient's clinical record. SF 509 may also be used whenever detailed clinical progress of dental treatment is necessary. In such instances, the SF 509 should be retained in the dental carrier jacket.

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FPMR (41 CFR) 101-11.6 OCTOBER 1975

HEALTH RECORD

DENTAL

SECTION I. DENTAL EXAMINATION

1. PURPOSE OF EXAMINATION

☒ INITIAL ☐ SEPARATION ☐ OTHER (Specify)

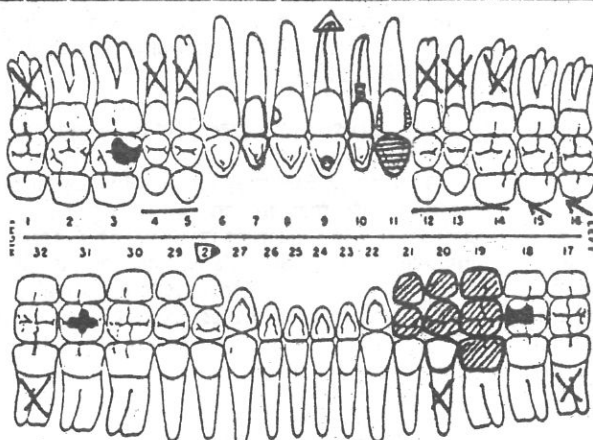
2. TYPE OF EXAM.

☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☒ 7 ☐ 8 ☐ 9

3. DENTAL CLASSIFICATION

☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

4. MISSING TEETH AND EXISTING RESTORATIONS



REMARKS

Chrome alloy Max RPD with acrylic teeth replacing 4, 5, 12, 13 & 14

Porcelain crown - 7

Resin Crown - 10

Acrylic facing, pontic - 20

PLACE OF EXAMINATION

NRDC Great Lakes IL

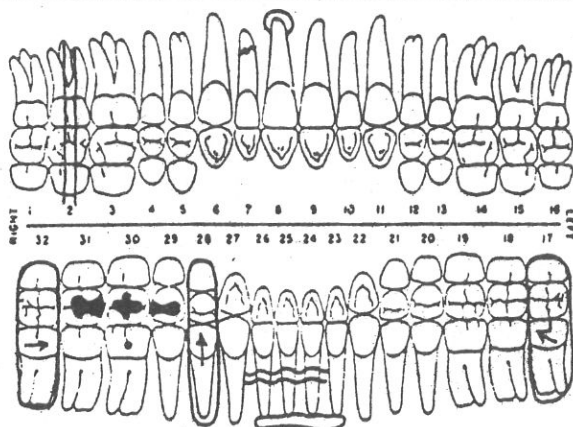
DATE

28 Aug 75

SIGNATURE OF DENTIST COMPLETING THIS SECTION

C. B. SMITH, CAPT, DC, USN

5. DISEASES, ABNORMALITIES, AND X-RAYS



A.

CALCULUS

☐ SLIGHT ☒ MODERATE ☐ HEAVY

B.

PERIODONTITIS

☒ LOCAL ☐ GENERAL

☐ INCIPIENT ☐ MODERATE ☒ SEVERE

C.

STOMATITIS (Specify)

X

GINGIVITIS

VINCENT'S

D.

DENTURES NEEDED

(Include dentures needed after indicated extractions)

FULL

PARTIAL

U

L

X

U

L

ABNORMALITIES OF OCCLUSION-REMARKS

7, 8, 9 & 10 overbite approximately 10 mm.

7 overlaps 8 by 2 mm.

15 & 16 tilted mesially so only distal cusp in occlusion

Perio-Case Type 3

E. INDICATE X-RAYS USED IN THIS EXAMINATION

☐ FULL MOUTH PERIAPICAL ☒ POSTERIOR SITE-WINGS ☐ OTHER (Specify) ☒ PAN

DATE

28 Aug 75

PLACE OF EXAMINATION

NRDC Great Lakes IL

SIGNATURE OF DENTIST COMPLETING THIS SECTION

C. B. SMITH, CAPT, DC, USN

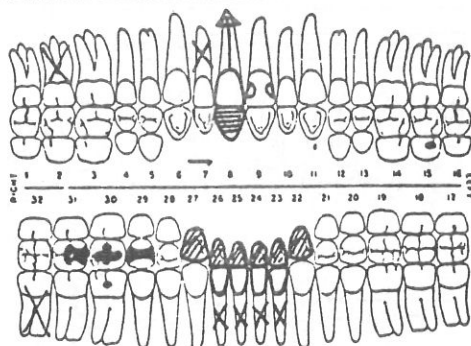
SECTION II. PATIENT DATA

6. SEX M	7. RACE CAU	8. GRADE, RATING, OR POSITION Recruit	9. ORGANIZATION UNIT C940	10. COMPONENT OR BRANCH USN	11. SERVICE, DEPT., OR AGENCY DOD
12. PATIENT'S LAST NAME-FIRST NAME-MIDDLE NAME DOE, John Joseph				13. DATE OF BIRTH (DAY-MONTH-YEAR) 1 Aug 57	14. IDENTIFICATION NO. SSN 111-22-3333

DENTAL
Standard Form 608
603-103

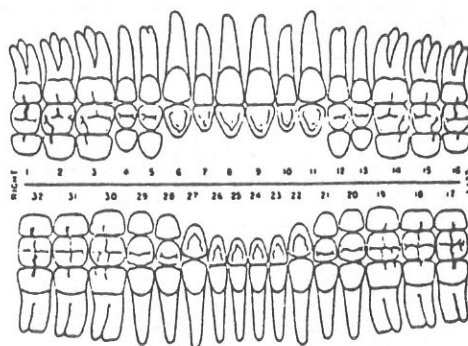
SECTION III. ATTENDANCE RECORD

15. RESTORATIONS AND TREATMENTS (Completed during service)



REMARKS

16. SUBSEQUENT DISEASES AND ABNORMALITIES



REMARKS

17. SERVICES RENDERED

DATE	DIAGNOSIS—TREATMENT	CLASS	OPERATOR AND DENTAL FACILITY	INITIALS
1SEP75	2-Ext. Anes.	2	C. J. Adams NRDC Great Lakes IL	
7SEP75	Gvtis. Tr., Scl., PCI	3	Dr. R. Adams NRDC Great Lakes IL	
9SEP75	Pro-SnF2, Top-SnF2, PCI	3	Dr. R. Adams NRDC Great Lakes IL	
10CT75	30-0-deep, ACR, Ca(OH)2, ZnOE, Anes.	3	Dr. R. Adams NRDC Great Lakes IL	
8OCT75	30-0-F-Ca(OH)2, Varn.-Am., 31-MO-Varn., Cem.B., Am., Anes.	3	Dr. R. Adams NRDC Great Lakes IL	
14OCT75	29-MOD-Ca(OH)2, Varn., Am., Anes.	3	Dr. R. Adams NRDC Great Lakes IL	
23OCT75	32-Surg.Ext., Su., Anes.	3	Dr. R. Adams NRDC Great Lakes IL	
25OCT75	32-POT	3	Dr. R. Adams NRDC Great Lakes IL	
27OCT75	32-Alveolar osteitis, Su. removed	3	Dr. R. Adams NRDC Great Lakes IL	
	Eug. Drs.	3	C. J. Adams NRDC Great Lakes IL	
28OCT75	32-POT, Eug. Drs.	3	C. J. Adams NRDC Great Lakes IL	
30OCT75	32-POT	3	C. J. Adams NRDC Great Lakes IL	
16NOV75	8-RCT, CMCP, Anes.	3	Dr. R. Adams NRDC Great Lakes IL	
17NOV75	8-RCT, CMCP	3	Dr. R. Adams NRDC Great Lakes IL	
19NOV75	8-RCT, CMCP	3	Dr. R. Adams NRDC Great Lakes IL	
20NOV75	8-RCT, GP Pt., Apv., Cur., Anes.	3	Dr. R. Adams NRDC Great Lakes IL	
30NOV75	8-Ceramo-metal Cr., ZnPol cem., SUPER-U. Porc., CASTO alloy	3	NRDC Great Lakes IL	
5JAN76	Abs. incised, drn. labial anterior man. area 23,24,25,26 penicillin 250 mg q.i.d. x 10 days	3	Dr. R. Adams NRDC Norfolk VA	
7JAN76	23 to 26 POT	3	Dr. R. Adams NRDC Norfolk VA	
14JAN76	23 to 26 Ext., Alvy., Su., Anes.	3	Dr. R. Adams NRDC Norfolk VA	
17JAN76	23 to 26 POT, Su. removed	3	Dr. R. Adams NRDC Norfolk VA	
12FEB76	Prepared 22 & 27 for three-quarter crowns. Temp. FPD 22 to 27 Ins., Anes.	3	Dr. R. Adams NRDC Norfolk VA	
1MAR76	22,23,24,25,26,27 -FPD Ins., SUPALLOY Alloy, Resin facings on pontics, PCI	3	Dr. R. Adams NRDC Norfolk VA	
8MAR76	7-Ext., Anes.	3	NRDC Norfolk VA	
12MAR76	Max. RPD (tooth added)	3	Dr. R. Adams NRDC Norfolk VA	
16MAR76	9-D-Ca(OH)2-Resin, Anes.; 15-L-Am. 9-M-Resin "Civ"	2	Dr. R. Adams NRDC Norfolk VA	
6JUL76	17-Eruption noted, 17 Pecor. Tr.	2	Dr. R. Adams NRDC Norfolk VA	

PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME

DOE, John Joseph

IDENTIFICATION NO.

111-22-3333

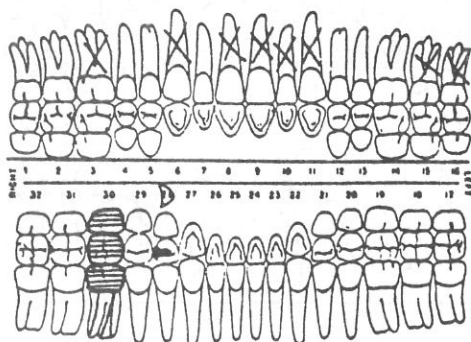
Standard Form 603-A

HEALTH RECORD

DENTAL—Continuation

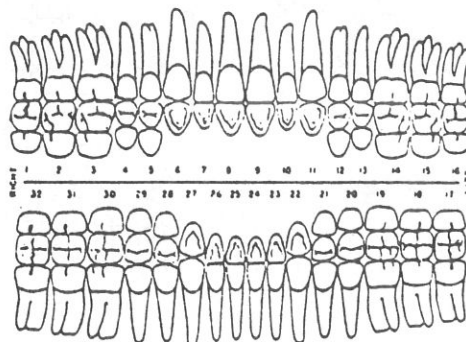
SECTION III. ATTENDANCE RECORD

15. RESTORATIONS AND TREATMENTS (Completed during service)



REMARKS

16. SUBSEQUENT DISEASES AND ABNORMALITIES



REMARKS

17. SERVICES RENDERED

DATE	DIAGNOSIS—TREATMENT	CLASS	OPERATOR AND DENTAL FACILITY	INITIALS
2AUG76	Exam. (type 2), Pro-SnF2, Top-SnF2	2	Ed. G. Owen NRDC Norfolk VA	
30AUG77	NUG Tr.-ultrasonic Scl. (Saline irrigation q.2 h. x 24 hrs.)		Ed. G. Owen USS SARATOGA	
31AUG77	NUG Tr.-continue irrigation	3	Ed. G. Owen USS SARATOGA	
2SEP77	Exam. (type 2), PCI	3	Ed. G. Owen USS SARATOGA	
7SEP77	Reinforce PCI	3	Ed. G. Owen USS SARATOGA	
4OCT77	30-RCT, establish drn.	3	Ed. G. Owen USS SARATOGA	
6OCT77	30-RCT	3	Ed. G. Owen USS SARATOGA	
8OCT77	30-RCT, GP Pts.	3	Ed. G. Owen USS SARATOGA	
20OCT77	30-Gold Cr., PCI	2	Ed. G. Owen USS SARATOGA	
1JUN78	Pro-SnF2, Top-SnF2, PCI	2	G. Owen BRDENCL Mayport FL	
7AUG79	Exam. (type 2)			
	NPD1 (1) (2) NPI (6) (7) (9), PCI			
	Pro-SnF2, Top-SnF2	2	Ed. G. Owen BRDENCL Mayport FL	
27AUG79	28-Do-Ca(OH)2, Varn., Am., Anes.			
	Max. RPD Rep.	2	Ed. G. Owen BRDENCL Mayport FL	
23DEC79	Max. bilateral Fx.			
	8, 9, 10-avulsed			
	3, 6, 11, 15-Fx.	3	Ed. G. Owen NRMC JAX FL	
25DEC79	Skeletal fixation of Max. Fx.			
	3, 6, 11, 15, 16-Ext., Alvy.			
	Su., General Anes. Patient refused			
	precious metal, disposed of as scrap	3	Ed. G. Owen NRMC JAX FL	
26DEC79	POT	3	Ed. G. Owen NRMC JAX FL	
27DEC79	POT	3	Ed. G. Owen NRMC JAX FL	
3JAN80	POT, Su. removed	3	Ed. G. Owen NRMC JAX FL	
5JAN80	POT	3	Ed. G. Owen NRMC JAX FL	
14FEB80	Max. CD, Man.FPD Rep.	2	Ed. G. Owen BRDENCL Mayport FL	
23MAY80	Max. CD relined	1	Ed. G. Owen BRDENCL Mayport FL	
5AUG80	Exam. (type 2)			
	Pro-SnF2, Top-SnF2, PCI	1	Ed. G. Owen BRDENCL Mayport FL	

PATIENT'S LAST NAME FIRST NAME MIDDLE NAME

11-22-3333
IDENTIFICATION NO.

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FPMR 101-11.205-4
OCTOBER 1979 603-305

Section XVI. DENTAL OFFICER TRAINING

	Article
General Practice Residency Programs in Dentistry	6-122
Basic Course of Indoctrination for Dental Officers	6-123
Postdoctoral Fellowship Program	6-124
Graduate Level Program at National Naval Dental Center	6-125
Naval Residency Training	6-126
Short Postgraduate Continuing Education Courses in Naval Facilities	6-127
Training in Civilian Schools	6-128
Selection and Submission of Requests for Training	6-129
Correspondence Courses	6-130
Audiovisual Resources	6-131

6-122. General Practice Residency Programs in Dentistry

(1) General Practice Residency Programs in Dentistry of 12 months' duration are conducted at naval graduate training medical centers. The training programs are designed to advance the knowledge and broaden the clinical experience of the recently graduated dental officer.

6-123. Basic Course of Indoctrination for Dental Officers

(1) All newly appointed dental officers, except those who have received indoctrination training prior to reporting for active duty, will be ordered to designated dental facilities for basic indoctrination. Such training is designed to familiarize new dental officers with the conduct of dental practice within the Navy and with Navy and Medical Department regulations and administrative practices.

6-124. Postdoctoral Fellowship Program

(1) Postdoctoral fellowships may be available to dental officers of the Regular Navy in clinical fields of endodontics, oral surgery, periodontics, preventive dentistry, prosthodontics, and research provided that there is a need for officers with this level of training.

(2) A postdoctoral fellowship is a 12-month in-service period of academic study and clinical training designed to improve the competency of the general dentist in the area of a single specialty discipline.

(3) The program is designed to accomplish one or more of the following objectives:

(a) Provide in-service training for the junior dental officer for further development of the officer's full potential as a dentist and to qualify the junior officer to serve in those general dentistry billets requiring significant experience in a single specialty discipline but not requiring board trained or certified personnel.

(b) Provide an opportunity for the most experienced or more senior officer to further develop clinical abilities.

(c) Provide the young dental officer an opportunity for self-evaluation of competency to specialize.

(d) Provide the opportunity for the dental officer to develop interests, proficiency, and motivation for further training.

(e) Provide senior dental officers an opportunity to evaluate junior dental officers for further training.

(4) Candidates are selected by the BUMED Dental Training Committee on a competitive basis determined by the qualifications of the candidates. A prerequisite for selection is a tour of sea or overseas shore duty as a dental officer. Other considerations include a demonstrated interest in a specialty as evidenced by clinical practice, participation in continuing education courses, including correspondence courses, or previous application for similar training.

(5) Completion of a postdoctoral fellowship will not preclude future assignment to a course at the National Naval Dental Center, naval residency training, or a long graduate or postgraduate course at a civilian university.

6-125. Graduate Level Program at National Naval Dental Center

(1) A 1-year graduate level program in Advanced Clinical Dentistry at the National Naval Dental Center, Bethesda, MD is designed to update the dental officer's professional knowledge in the clinical, scientific, and military aspects of Navy dentistry. To a lesser degree the curriculum includes basic sciences, theory, dental research, naval dental administration, management, and leadership. The program is primarily for dental officers with 6 to 10 years of clinical experience who desire to develop a high degree of proficiency in all current disciplines in the practice of general clinical dentistry in the Navy. Dental officers of the Regular Navy (or officers who

have requested augmentation into the Regular Navy), who will have served a minimum of 4 years on active duty as a dental officer, are eligible to apply for this course. Generally, the 4-year period should include either a tour of sea, FMF, or overseas shore duty. Applications for this graduate level course in Advanced Clinical Dentistry at the National Naval Dental Center should be made in accordance with article 6-129.

6-126. Naval Residency Training

(1) Residency training in comprehensive dentistry, endodontics, oral medicine, periodontics, operative dentistry, maxillofacial prosthetics, and prosthodontics are conducted at the National Naval Dental Center, Bethesda, MD. Residency training in oral surgery and general practice residency are conducted at various naval regional medical centers. Residency training in dental specialties is available to a limited number of dental officers of the Regular Navy (or officers who have requested augmentation into the Regular Navy) who will have served a minimum of 4 years on active duty as a dental officer, before the convening date of the next school year. Generally, the 4-year period should include either a tour of sea, FMF, or overseas shore duty. Dental officers who are currently in their first year of residency will ordinarily continue in 2- and/or 3-year programs without having to reapply. Applicants for all residency programs must have scholastic records indicative of the ability to pursue advanced education and a sincere interest and aptitude for the specialty. Applications should be submitted in accordance with article 6-129.

6-127. Short Postgraduate Continuing Education Courses in Naval Facilities

(1) Continuing education courses in various disciplines of dentistry are available to active duty dental officers and to inactive duty dental officers of the Naval Reserve on a space available basis. These courses are available at the National Naval Dental Center, Bethesda, MD and at the Naval Regional Dental Center, San Diego, CA. Dental officers may obtain information regarding the availability of continuing education courses from the Naval Health Sciences Education and Training Command (HSETC). Applications shall be submitted in accordance with article 6-129.

6-128. Training in Civilian Schools

(1) Graduate and postgraduate courses of 1 to 3 academic years duration are available in limited numbers to dental officers of the Regular Navy. Candidates for these courses are selected from applicants who have outstanding aptitude for the specialty concerned and have an undergraduate and a dental

school scholastic record indicative of ability to pursue advanced education, i.e., at least "B" average. Candidates are selected by the BUMED Dental Training Committee on a competitive basis determined by the qualifications of the candidates. A prerequisite for selection is a minimum of 4 years active duty as a dentist. Generally, the 4-year period should include either a tour of sea duty, FMF, or overseas shore duty. Other considerations include a demonstrated interest in a specialty as evidenced by clinical practice, participation in continuing education courses, including correspondence courses, or previous application for similar training. Programs in comprehensive dentistry, oral pathology, endodontics, oral medicine, periodontics, operative dentistry, and prosthodontics are available. Dental officers may also be trained in special areas not normally available within the naval service such as orthodontics, public health dentistry, oral roentgenology, pedodontics, research, dental education, basic sciences, and allied dental sciences, dependent upon the needs of the service. The Navy will pay tuition and fees by separate fiscal year contracts for candidates approved for such training. Dental officers in civilian programs will be reimbursed for personal funds expended for necessary textbooks, instruments and supplies, thesis preparation costs, etc., within the limits defined by the Naval Health Sciences Education and Training Command in its final approval letter. No Navy funds are available to support research projects that may be a part of courses in civilian institutions. Dental officers are not allowed to receive stipends while in training.

(2) The costs for attendance at professional meetings and conferences will be paid by using resources included for this purpose in the local expense operating budget under the Operations and Maintenance, Navy, Medical Support account for officers at activities under the command of the Chief, Bureau of Medicine and Surgery. Requests from officers at BUMED command activities, to attend professional meetings and conferences therefore, will be approved and funded locally. If funds are not available for continuing education courses at BUMED or non-BUMED command activities, authorization orders may be issued for attendance at approved courses so that leave for this purpose will not be necessary. Dental officers may obtain information regarding the availability of continuing education courses from HSETC. Additional information is available in BUMEDINST 4651.1 series.

6-129. Selection and Submission of Requests for Training

(1) Applications for the General Practice Residency Programs in Dentistry (art. 6-122) must be submitted prior to 1 October of the applicant's senior year in dental school. Dental students who are not members of the Ensign 1925 (I) Programs should

apply through a Navy recruiting district. Early in their senior year, dental student members of the Ensign 1925 (I) Program will automatically receive information about the General Residency Programs. Selection is made by a board convened at BUMED early each November.

(2) Dental officers of the Regular Navy (or officers who have requested augmentation into the Regular Navy) who have served a minimum of 4 years on active duty as a dental officer, before the convening date of the next class, are eligible to apply for advanced training. Those who apply should request the appropriate institution to forward pre-dental and dental school scholastic record transcripts and other transcripts of scholastic records so as to be received in the Naval Health Sciences Education and Training Command (Code 32) not later than 1 July preceding the year training will commence (applicant must pay any procurement costs). Each candidate's application should include (a) a first and second choice of the type of training desired, i.e., a request for a postdoctoral fellowship or a graduate level course in prosthodontics, etc., in order of choice, and (b) a statement of motivation concerning the applicant's background, interest, and reasons for requesting such training. This information should be consistent with the applicant's known abilities and career plan. Second choices in a discipline outside the primary interest will be accepted but are not encouraged. Applicants will not be considered in instances where assignment to training would make it necessary to significantly prolong or shorten a normal tour of sea or overseas duty. Disapproval does not preclude submission of an application for the same or for other training at a later date. Officers presently in training in a dental specialty need not apply for continuation; i.e., second- and/or third-year level of training. Candidates are referred to NAVMED P-5093, Dental Officer Education Programs, and NAVEDTRA 10500 Catalog of Navy Training Courses (CANTRAC), Volume IX, Navy Medical Department Courses, for further information relative to advanced training. Copies of the catalog of advanced courses at the National Naval Dental Center may be obtained by directing requests to the Commanding Officer, National Naval Dental Center, Bethesda, MD 20014.

(3) Applications for full-time training in civilian institutions must be submitted via the chain of command so as to be received in the Naval Health Sciences Education and Training Command (Code 32), not later than 1 July preceding the year training will commence. Submission 1 year in advance enables those officers selected to meet application deadlines established by civilian universities.

(4) Applications for postdoctoral fellowships, advanced courses at the National Naval Dental Center, and residency training at naval facilities also must be submitted via the chain of command so as to be received in the Naval Health Sciences Education and

Training Command (Code 32), prior to 1 July, preceding the year training will commence.

(5) Requests for short postgraduate continuing education courses at the National Naval Dental Center should be submitted to the Naval Health Sciences Education and Training Command (Code 32). Requests for courses at the Naval Regional Dental Center, San Diego are submitted to the Commanding Officer, Naval Regional Dental Center, San Diego, CA. These requests should be submitted via official channels so as to be received at least 6 weeks before the convening date of the course. When there is insufficient time to submit a request by letter, a message request may be submitted with information copies to the appropriate fleet commands.

(6) All advanced/graduate level training requests are reviewed by the Dental Training Committee. Applications are judged individually by considering many factors which include:

- (a) Projected staffing needs of the Navy Dental Corps.
- (b) Availability of funds.
- (c) Applicant's academic background.
- (d) Applicant's age and experience.
- (e) Applicant's performance record.
- (f) Career pattern. In this regard, selection and assignments to full-time training are made from those officers considered best qualified for advanced study and for subsequent positions of increased responsibility.

(g) Completion of tours of duty relative to commencement of training. An officer cannot expect to have an overseas tour, etc., prematurely curtailed so that full-time training may be entered.

(7) To obtain uniformity in requests and supporting data, the following letter forms shall be used depending upon the type of instruction desired:

(a) *Long Courses of Instruction at Civilian Universities.*—

From: *(Name of applicant)*
 To: Commanding Officer; Naval Health Sciences Education and Training Command (Code 32), National Naval Medical Center, Bethesda, MD, 20014
 Via: Commanding Officer
 Subj: Advanced education
 End: (1) Statement of Motivation

1. It is requested that I be considered for assignment to a long course in *(discipline)* at a civilian institution for the period *(month and year to month and year)*. *(If the candidate would accept a Navy course in the same discipline, he/she may add the sentence "I would accept a Navy residency, or post-doctoral fellowship in the same specialty.")* My present duty assignment commenced on *(date)*.

2. Transcripts and a letter of recommendation (*have been/are being*) forwarded. A statement of motivation, enclosure (1), is also provided.

3. If this request for a course in a civilian institution is approved and I am assigned to such training, I agree not to resign during the course and to serve in the Navy for (*enter service obligation in accordance with BUMEDINST 1520.7 series*) plus any previously unfulfilled minimum service requirement after completion of the course. I understand that this period of obligated service is in addition to that for which I may be previously and otherwise obligated and may not be performed concurrently.

4. I understand the Privacy Act of 1974 (P.L. 93-579) became effective on 27 September 1975 and is applicable to personal data records maintained on U.S. citizens and foreign nationals admitted for permanent residence. My signature acknowledges that I am familiar with the statement contained herein and authorizes use of information provided for the purposes listed.

PRIVACY ACT STATEMENT

The authority to request this information is contained in 5 U.S.C. 301 Department Regulations. The principle purpose of the information is to enable you to make known your desire for the Naval Health Sciences Education and Training Command to initiate and maintain a training file on your behalf. The information will be used to assist officials and employees of the Department of the Navy in determining your eligibility for and approving or disapproving the education authorization being requested. Completion of this form is mandatory; failure to provide required information may result in delay in response to or disapproval of your request.

(Signature)

If the request is approved, BUMED will instruct the applicant to apply to one or more civilian schools and when accepted submit a letter to HSETC as shown in the following example. Officers should not apply to civilian schools for admission until instructed to do so by BUMED.

From: (Name of applicant)
 To: Commanding Officer, Naval Health Sciences Education and Training Command (Code 32), National Naval Medical Center, Bethesda, MD 20014
 Via: Commanding Officer
 Subj: Advanced education
 Ref: (a) (Letter from BUMED approving your request to apply to a civilian school for a long course)
 Encl: (1) Copy of letter of acceptance from (name of institution) dated ()
 (2) Cost quotation for naval officers in civilian institutions

1. Reference (a) approved my request to apply for a long course at a civilian institution.

2. I have applied to the (*school and location*) and have been accepted for (*an advanced/graduate*) course in (*discipline*) for the period (*month, day, and year, to month, day, and year*) at a total cost of (\$), enclosures (1) and (2). Final approval for subject course is hereby requested.

3. I understand that tuition and fees, except for my original application fee, will be paid by the Navy by separate fiscal year contracts and that I will be reimbursed for personal funds expended for necessary textbooks, instruments, and certain supplies, thesis preparation costs, etc., within the limits defined by HSETC in my final approval letter. I also understand that no Navy funds are available to support research projects that may be a part of my course of instruction at (*name of institution*).

(Signature)

(b) *Residency Training in a Naval Facility (which includes the following programs).—*

Oral Surgery
 Comprehensive Dentistry
 Operative Dentistry
 Endodontics
 Maxillofacial Prosthetics
 Oral Medicine
 Periodontics
 Prosthodontics

From: (Name of applicant)
 To: Commanding Officer, Naval Health Sciences Education and Training Command (Code 32), National Naval Medical Center, Bethesda, MD 20014
 Via: Commanding Officer

Subj: Advanced education

Encl: (1) Statement of Motivation

1. It is requested that I be considered for assignment to residency training in (*discipline*), commencing in (*month and year*). (If applicable, the following statement should be included: "I would accept a Navy postdoctoral fellowship in the same specialty.") My present duty assignment commenced on (*date*).

2. Transcripts and a letter of recommendation (*have been/are being*) forwarded. A statement of motivation, enclosure (1), is also provided.

3. If this request is approved, I hereby agree not to resign during the course and to serve in the Navy for (*enter service obligation in accordance with BUMEDINST 1520.7 series*) plus any unfulfilled minimum service requirement after completion of the course. I understand that this period of obligated service is in addition to that for which I may be

previously and otherwise obligated and may not be performed concurrently.

4. I understand the Privacy Act of 1974 (P.L. 93-579) became effective on 27 September 1975 and is applicable to personal data records maintained on U.S. citizens and foreign nationals admitted for permanent residence. My signature acknowledges that I am familiar with the statement contained herein and authorizes use of information provided for the purposes listed.

PRIVACY ACT STATEMENT

The authority to request this information is contained in 5 U.S.C. 301 Department Regulations. The principle purpose of the information is to enable you to make known your desire for the Naval Health Sciences Education and Training Command to initiate and maintain a training file on your behalf. The information will be used to assist officials and employees of the Department of the Navy in determining your eligibility for and approving or disapproving the education authorization being requested. Completion of this form is mandatory; failure to provide required information may result in delay in response to or disapproval of your request.

(Signature)

(c) *Graduate Level Program in Advanced Clinical Dentistry, National Naval Dental Center, Bethesda, MD.—*

From: (Name of applicant)

To: Commanding Officer, Naval Health Sciences Education and Training Command (Code 32), National Naval Medical Center, Bethesda, MD 20014

Via: Commanding Officer

Subj: Advanced education

Encl: (1) Statement of Motivation

1. It is requested that I be considered for assignment to the next class in (*Advanced Clinical Dentistry*) at the National Naval Dental Center, Bethesda, MD. My second choice is (see 6-129(2)(a) above). (*If there is no second choice, add the sentence, "I have no second choice."*) My present duty assignment commenced on (*date*).

2. Transcripts and a letter of recommendation (*have been/are being*) forwarded. A statement of motivation, enclosure (1), is also provided.

3. If this request is approved, I hereby agree not to resign during the course and to serve in the Navy for (*enter service obligation in accordance with BUMEDINST 1520.7 series*) plus any unfulfilled minimum service requirement after the completion of the course. I understand that this period of obligated service is in addition to that for which I may be

previously and otherwise obligated and may not be performed concurrently.

4. I understand the Privacy Act of 1974 (P.L. 93-579) became effective on 27 September 1975 and is applicable to personal data records maintained on U.S. citizens and foreign nationals admitted for permanent residence. My signature acknowledges that I am familiar with the statement contained herein and authorizes use of information provided for the purposes listed.

PRIVACY ACT STATEMENT

The authority to request this information is contained in 5 U.S.C. 301 Department Regulations. The principle purpose of the information is to enable you to make known your desire for the Naval Health Sciences Education and Training Command to initiate and maintain a training file on your behalf. The information will be used to assist officials and employees of the Department of the Navy in determining your eligibility for and approving or disapproving the education authorization being requested. Completion of this form is mandatory; failure to provide required information may result in delay in response to or disapproval of your request.

(Signature)

(d) *Postdoctoral Fellowship.—*

From: (Name of applicant)

To: Commanding Officer, Naval Health Sciences Education and Training Command (Code 32), National Naval Medical Center, Bethesda, MD 20014

Via: Commanding Officer

Subj: Advanced education

Encl: (1) Statement of Motivation

1. It is requested that I be considered for assignment to postdoctoral fellowship training in (*discipline*) commencing in (*month and year*). My second choice is (see 6-129(2)(a) above). (*If there is no second choice, add the sentence, "I have no second choice."*) My present duty assignment commenced on (*date*).

2. Transcripts and a letter of recommendation (*have been/are being*) forwarded. A statement of motivation, enclosure (1), is also provided.

3. I understand the Privacy Act of 1974 (P.L. 93-579) became effective on 27 September 1975 and is applicable to personal data records maintained on U.S. citizens and foreign nationals admitted for permanent residence. My signature acknowledges that I am familiar with the statement contained herein and authorizes use of information provided for the purposes listed.

PRIVACY ACT STATEMENT

The authority to request this information is contained in 5 U.S.C. 301 Department Regulations. The principle purpose of the information is to enable you to make known your desire for the Naval Health Sciences Education and Training Command to initiate and maintain a training file on your behalf. The information will be used to assist officials and employees of the Department of the Navy in determining your eligibility for and approving or disapproving the education authorization being requested. Completion of this form is mandatory; failure to provide required information may result in delay in response to or disapproval of your request.

(Signature)

(e) *Short Postgraduate Continuing Education Courses at Civilian Universities For Those Dental Officers at Non-BUMED Funded Activities.*—

From: (Name of applicant)
To: Commanding Officer, Naval Health Sciences Education and Training Command (Code 32), National Naval Medical Center, Bethesda, MD 20014
Via: Commanding Officer

Subj: Continuing education course

1. It is requested that I be assigned to a continuing education course in (course) to be held at (school and location) during the period (day and month to day and month).

2. The total cost of the course is (), which is for tuition.

(Signature)

(f) *Short Postgraduate Continuing Education Courses at the National Naval Dental Center.*—

From: (Name of applicant)
To: Commanding Officer, Naval Health Sciences Education and Training Command (Code 32), National Naval Medical Center, Bethesda, MD 20014
Via: Commanding Officer

Subj: Continuing education course

1. It is requested that I be assigned to a continuing education course in (course) to be held (location) during the period (day and month to day and month).

(Signature)

(g) *Short Postgraduate Continuing Education Courses at the Naval Regional Dental Center, San Diego.*—

From: (Name of applicant)
To: Commanding Officer, Naval Regional Dental Center, San Diego, CA 92136
Via: Commanding Officer

Subj: Continuing education course

1. It is requested that I be assigned to a continuing education course in (course) to be held (location) during the period (day and month to day and month).

(Signature)

6-130. Correspondence Courses

(1) A wide variety of correspondence courses is available to dental officers. These courses and instructions for enrollment are shown in NAVPERS 10061, List of Training Manuals and Correspondence Courses, latest edition; and in NAVMED P-5081, Correspondence Course Program—U.S. Navy Dental Corps. Information on the courses may be obtained by writing to the Commanding Officer (Code 413), National Naval Dental Center, Bethesda, MD 20014.

6-131. Audiovisual Resources

(1) *Films.*—The requirements and responsibilities in the production, distribution, and procurement of medical, dental, and naval training films are specified in BUMEDINST 1551.1 series.

(2) *Exhibits.*—The procedures for requesting construction and presentation of exhibits are prescribed in BUMEDINST 5722.1 series.

(3) *Training Course Manuals.*—Dental Technician Training Manuals can be obtained from the Navy Supply System.

(4) *Resources available on request* from the Commanding Officer, National Naval Dental Center, Bethesda, MD 20014, are as follows:

- (a) Histopathological microscopic slide sets.
- (b) Dental training films (16mm and 8mm).
- (c) Dental videocassettes in 3/4 inch size.
- (d) Lecture sets with color transparencies.
- (e) Synchronized slide/audiotape programs.
- (f) Lists of educational materials available from sources other than the National Naval Dental Center.

(5) *Audiovisual Resources.*—A comprehensive listing of available audiovisual resources is provided in the Media Catalog of the National Naval Dental Center, Bethesda, MD 20014.

Section XVII. DENTAL RESEARCH

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6-133. Policy

(1) The fundamental policy of BUMED is to encourage and support research and development in the field of dentistry which is directed toward the solution of problems affecting the health, safety, selection, efficiency, and combat effectiveness of personnel of the Department of the Navy and other branches of the DOD.

(2) The direction of dental research facilities shall be done by the Naval Medical Research and Development Command in coordination with the Dental Division of BUMED.

(3) Although there shall be no fixed apportionment of clinical or applied research, the staffs of naval dental research facilities are particularly well qualified to understand and solve clinical dental research problems affecting naval personnel.

6-134. Objectives

(1) The first objective of naval dental research is to develop dental health programs that support specific operational requirements as promulgated by the Chief of Naval Operations.

(2) The second objective is to provide applied or clinical research support to the patient care programs of the naval Dental Corps. It must give direct assistance to the naval Dental Corps in its primary mission of preventing and remedying those dental defects which interfere with the performance of official duties.

6-134A. Facilities

(1) The Naval Dental Research Institute, Naval Base, Great Lakes, Illinois, is established as the prime dental research center. This activity, which is under the command and support of the Commanding Officer, Naval Medical Research and Development Command, has a dental officer as commanding officer. Other dental research facilities are maintained at the National Naval Dental Center and the Naval Medical Research Institute, Bethesda, Maryland, and in certain naval medical research facilities.

6-134B. Personnel

(1) Dental research facilities may be staffed by dental officers, Medical Corps officers, Nurse Corps officers, Medical Service Corps officers, dental technicians, hospital corpsmen, and civilians.

(2) The importance of maintaining continuity and productivity in research programs is recognized and will be given just consideration.

(3) Interested personnel with special aptitude, training, experience, or inclination for research should notify BUMED relative to their desire for duty in research, stating their special qualifications and fields of interest.

6-134C. Projects

(1) Dental research projects that support the objectives outlined in article 6-134 are initiated by individual investigators who submit their proposals via official channels to the Commanding Officer, Naval Medical Research and Development Command for approval. However, BUMED may assign, via official channels, projects to any dental research facility when investigations are required for specific problems.

(2) The selection of a dental research project will depend on its importance to the Navy, the qualifications of the investigators, the available facilities, and the special opportunities offered by the location and environment of the particular establishment.

6-134D. Reports

(1) Reference should be made to chapter 20 for information on research reports and publication of research articles.

6-134E. Use of Human Volunteers

(1) Specific guidelines are outlined in chapter 20, SECNAVINST 3900.39 series, and BUMEDINST 3900.6 series pertaining to the use of human volunteers in research projects.

6-134F. Trials of Commercial Items

(1) Authority to conduct clinical, laboratory, or field trials at naval activities of drugs, materials, or devices covered by the Federal Food, Drug, and Cosmetic Act may be granted by BUMED provided

certain criteria outlined in chapter 20 are met. Procedures for obtaining approval are outlined in BUMEDINST 6710.49 series.

(2) Procedures for recommending standardization, testing, and evaluation of dental materials are contained in BUMEDINST 6700.33 series.

Section XVIII. NATIONAL NAVAL DENTAL CENTER

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6-135. Establishment

(1) The National Naval Dental Center had its beginning in 1922 as a Department of Dentistry in the Naval Medical School at Constitution Avenue and 23rd Street, N.W., Washington, D.C. In 1923, it became known as the Naval Dental School and began to function as a teaching institution. It was inactive from 1932 to 1936, when it was reestablished by the Secretary of the Navy as a component of the Naval Medical Center in the same location. The Naval Medical Center, including the Dental School, moved to new quarters at Bethesda, MD, and was redesignated the National Naval Medical Center on 5 February 1942. On 17 November 1971, the Naval Dental School was redesignated the Naval Graduate Dental School and on 1 July 1975 as the National Naval Dental Center. The center provides outpatient dental care in the National Capitol Region and advanced education programs for dental officers.

6-136. Command, Support, and Area Coordination

(1) The National Naval Dental Center is under the primary support of BUMED. The center is under the area coordination of the Commandant, Naval District of Washington.

6-137. Mission and Functions

(1) *Mission.*—The mission of the National Naval Dental Center is: to provide comprehensive and specialized dental services to authorized and eligible beneficiaries; provide specialized treatment services in maxillofacial prosthodontics for instances of trauma, surgical, and developmental defects; provide oral histopathological services to fleet and shore activities; conduct clinical investigations in support of dental health care delivery; conduct dental residency training programs and continuing education courses; develop correspondence training courses; instruct and train enlisted dental personnel in designated technical specialties. Perform such other functions as may be directed by the Chief, Bureau of Medicine and Surgery.

(2) *Functions.*—As directed by the Chief, Bureau of Medicine and Surgery:

(a) Provide complete dental services to eligible personnel in the area and as referred from other fleet and shore activities.

(b) Provide complete dental services to eligible retired members of the military services, subject to the availability of space, facilities, and professional staff or where such treatment may be required in support of residency programs.

(c) Provide emergency dental services to civilian personnel and military dependents where such care is required for humanitarian reasons and when civilian professional care cannot be obtained.

(d) Provide maxillofacial prosthodontic rehabilitation treatment support for local trauma, surgical, and developmentally defective patients and others referred from fleet and shore activities Navy-wide.

(e) Operate the Navy oral histopathological center for all fleet and shore activities and act as a repository for records and microscopic slides submitted from all other Navy oral histopathological services.

(f) Provide and coordinate a preventive dentistry program for active duty and retired personnel in the area and other eligible beneficiaries as directed by higher authority.

(g) Maintain the administrative functions required to support the dental services rendered.

(h) Conduct indoctrination and training programs to ensure the military and professional competence of officer and enlisted personnel.

(i) Conduct clinical investigations in support of dental care delivery as required and approved and in support of residency programs.

(j) Originate, methodize, and administer BUMED sponsored officer residency programs in support of requirements of the oral health care delivery system.

(k) Originate, methodize, and administer dental continuing education courses at a graduate level for active duty and reserve dental officers and correspondence courses for Navy-wide use.

(l) Conduct training programs for enlisted dental personnel in technical specialties as designated by higher authority.

(m) Provide consultants to the Dental Division, BUMED relative to the various dental specialty disciplines.

(n) Provide or undertake such other appropriate functions as may be authorized or directed by higher authority.

6-138. Organization

(1) The center is organized under the command of an officer of the Dental Corps as designated by the Commander, Naval Military Personnel Command.

(2) The center is organized into departments to provide all clinical services under a director of clinical services, all administrative services under a director of administrative services, and all educational and research resources under a director of educational services.

Section XIX. NAVAL SCHOOLS OF DENTAL ASSISTING AND TECHNOLOGY

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Dental Laboratory Technology, Basic (Class C School)	6-142
Dental Laboratory Technology, Advanced (Class C School)	6-143
Dental Laboratory Technology, Maxillofacial (Class C School)	6-144
Dental Research Assistant (Class C School)	6-144A
Dental Equipment Repair Technology (Class C School)	6-144B

6-139. General Information

(1) The training program for dental technicians is divided into basic and specialized training. Basic training is accomplished at class A service schools and specialized training at class C service schools.

(2) Qualifications for admission to the various courses are listed in the Catalog of Navy Training Courses (CANTRAC) NAVEDTRA 10500.

6-140. Dental Assistant, Basic (Class A School)

(1) Class A school provides a basic training course for general technicians. Admission to the course is by approval of application or by direct recruitment. Any person in a naval rating may request admission to the course and a change of rating to the dental rating group. Such a request must include the recommendation of a dental officer, and must be addressed to the Commander, Naval Military Personnel Command via the Chief, Bureau of Medicine and Surgery. Successful completion of this training course is a prerequisite for further training and advancement in the dental technician rating.

6-141. Dental Assistant, Advanced (Class C School)

(1) Upon advancement to dental technician, second class, the technician becomes eligible for this training; however, it is not a prerequisite to eligibility for advancement in rating. The purpose of this course is to train the technician to perform effectively the administrative, clinical, and military duties required.

6-142. Dental Laboratory Technology, Basic (Class C School)

(1) This school is designed to provide specialized training necessary to qualify the dental technician for the performance of duties in a dental prosthetic laboratory.

6-143. Dental Laboratory Technology, Advanced (Class C School)

(1) After on-the-job training and upon advancement to dental technician, second class, the dental laboratory technician becomes eligible for this course of instruction.

(2) The purpose of this course is to prepare the dental laboratory technician for the responsibilities of a senior petty officer. The course includes instruction in fixed prosthetic appliances, ceramics, laboratory management, oral and written communications, military leadership, and personnel management. It is available to selected technicians but is not a prerequisite to eligibility for advancement in rating.

6-144. Dental Laboratory Technology, Maxillofacial (Class C School)

(1) Upon advancement to dental technician, second class, a technician who is a graduate of the Dental Laboratory Technology, Basic (Class C School) and who possesses a certain amount of artistic ability and normal color perception is eligible to apply for this course of specialized training. The purpose of this course is to acquaint trainees with the laboratory procedures in fabrication of maxillofacial appliances.

6-144A. Dental Research Assistant (Class C School)

(1) The Dental Research Assistant (Class C School) provides specialized instruction in the basic knowledge and skills required to conduct dental research procedures.

6-144B. Dental Equipment Repair Technology (Class C School)

(1) This course is designed to acquaint dental technicians with the procedures of installation, maintenance, and repair of equipment used in dental operating rooms and prosthetic laboratories.

Section XX. PUBLICATIONS AND FILES IN DENTAL FACILITIES

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6-145. Official Publications

(1) All dental facilities should have office copies of certain publications. It should not be necessary for dental officers, when transferred, to transport voluminous files of official reference material from one naval activity to another. All copies of manuals and other publications, and files for correspondence and reports, shall, at all times, be kept up to date and

ready for inspection. Dental officers, upon assuming charge or command of dental facilities, should determine if all required manuals and other publications are available and up to date. If any are missing, they should submit requests for them as provided in section I of NAVSUP Publication 2002. The following guide is provided for establishing and maintaining libraries of official publications in all dental facilities:

Publications for official use in dental facilities afloat and ashore

Number	Item	How Obtained
NAVMED P-117	Manual of the Medical Department, U.S. Navy	Letter to BUMED (see BUMEDINST 5215.4 series).
.....	U.S. Navy Regulations*	As provided in section I of NAVSUP Pub. 2002
.....	Navy Department General Orders*	Do.
.....	Manual for Courts Martial, United States 1969*	Do.
NAVMED P-5004	Handbook of the Hospital Corps, U.S. Navy	Do.
NAVMED P-5087	Preventive Dentistry	Do.
NAVPER 15791	Bureau of Naval Personnel Manual*	Do.
NAVPER 15018	Register of Commissioned and Warrant Officers of the United States Navy and Reserve Officers on Active Duty as provided for in BUPERSMAN 5420100*	Do.
NAVEDTRA 10681 series	Dentalman	Do.
NAVEDTRA 10682 series	Dental Technician, 3 and 2	Do.
NAVEDTRA 10683 series	Dental Technician, 1 and C	Do.
NAVEDTRA 10685 series	Dental Technician, Prosthetic	Do.
NAVEDTRA 10686 series	Dental Technician, General	Do.
NAVEDTRA 10687 series	Dental Technician, Repair	Do.
NAVEDTRA 10688 series	Preventive Dentistry and its Practice in the Navy	Do.
SECNAVINST 5210.11 series	Navy Standard Subject Identification Codes	Do.
SECNAVINST 5215.1 series	Navy Directives Issuance System	Do.
SECNAVINST 5216.5 series	Navy Correspondence Manual	Do.
SECNAVINST 6320.8 series	Uniformed Services Health Benefits Program	Do.
SECNAVINST 6800.1 series	Preventive Dentistry Program	Do.
DPSC C6500 et seq	Federal Supply Catalog, DOD Section, Medical Material	Do.
BUMEDINST 1221.2 series	Skill resource file for the DT rating; establishment of	Do.
BUMEDINST 1510.13 series	Specialty enlisted training committee for the DT rating, establishment of	Do.
BUMEDINST 1520.7 series	Minimum terms of service and active duty obligations for health service officers	Do.
BUMEDINST 3040.1 series	Naval Dental Corps Casualty Treatment Training Program	Do.
BUMEDINST 4010.2 series	Precious metals, recovery and utilization of	Do.
BUMEDINST 4235.5 series	Programming of investment equipment requirements	Do.

<i>Number</i>	<i>Item</i>	<i>How Obtained</i>
BUMEDINST 4651.1 series	Continuing education and professional update training for Medical Department personnel, funding of	Do.
BUMEDINST 5512.2 series	Name badges for staff personnel	Do.
BUMEDINST 5760.3 series	American Red Cross (ARC) volunteers assisting in naval dental facilities	Do.
BUMEDINST 6150.33 series	Medical and Dental Military Health Records; DD Forms 722 and 722-1; optional terminal digit-SSN filing system for	Do.
BUMEDINST 6260.19 series	Mercury Control Safety Program for dental facilities	Do.
BUMEDINST 6320.31 series	Medical and dental care for eligible persons at Navy Medical Department facilities	Do.
BUMEDINST 6320.32 series	Nonnaval medical and dental care	Do.
BUMEDINST 6320.60 series	Patient Contact Programs, establishment of	Do.
BUMEDINST 6440.3 series	Support to medical and dental department organizations of the Operating Forces	Do.
BUMEDINST 6470.9 series	Radiation protection survey and equipment performance test of diagnostic X-ray equipment	Do.
BUMEDINST 6510.8 series	Reference laboratories in anatomic and clinical pathology; designation of	Do.
BUMEDINST 6600.8 series	Dental Information Retrieval System (DIRS) Treatment Report (NAVMED 6600/9); preparation and submission of	Do.
BUMEDINST 6600.9 series	Sterilization or disinfection of dental instruments, supplies, and equipment	Do.
BUMEDINST 6670.1 series	Orthodontic care in naval dental facilities; provision of	Do.
BUMEDINST 6700.16 series	BUMED—controlled medical and dental equipment items, requisitioning of	Do.
BUMEDINST 6700.20 series	Procurement of nonstandard medical and dental material; report of	Do.
BUMEDINST 6700.33 series	Medical and dental items recommended for standardization or testing, procedure for	Do.
BUMEDINST 6700.36 series	Medical/dental equipment maintenance and repair manual	Do.
BUMEDINST 6700.37 series	Management of equipment	Do.
BUMEDINST 6710.59 series	Intravenous and inhalation agents to control pain and anxiety in dental patients; use of	Do.
BUMEDINST 6710.63 series	Defective or unsatisfactory medical and dental material, reporting and processing	Do.
BUMEDINST 6750.4 series	Dental Service Report Equipment and Facilities Supplement, DD Form 477-1; preparation and submission of	Do.
BUMEDINST 6820.4 series	Professional reference materials and publications; procurement of	Do.
.....	Navy Medical and Dental Materiel Bulletin	Commanding Officer, Navy Medical Materiel Support Command, 3500 South Broad St., Phila., PA 19145

*If required and not readily available within the command.

(2) Dental activities under BUMED command will require additional publications pertinent to the administration of the activity.

(3) All dental facilities should also maintain a library of professional publications as prescribed in BUMEDINST 6820.4 series.

6-146. Personal Copies of Official Publications

(1) All dental officers should be familiar with certain publications which describe the basic duties and responsibilities of naval dental officers. Dental officers desiring to maintain a personal copy of

official publications may do so at their own expense. They are available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

6-147. Department Files

(1) The files of dental facilities shall be arranged in accordance with current instructions.

(2) The commanding officer of a dental activity or the dental officer of a ship, station, or service shall retain and dispose of official correspondence in the files of the organization in accordance with SEC NAVINST 5212.5 series.

(3) Disposition of the dental folder and its contents shall be in accordance with SECNAVINST 5212.5 series.

Section XXI. REPORTS, RECORDS, AND CORRESPONDENCE

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6-148. General Instructions

(1) Reports shall be prepared and forwarded by the dental officer of a ship, station, or other activity in accordance with chapter 23 and other current directives.

(2) Official correspondence with BUMED shall be forwarded via the commanding officer. Information

copies of all official correspondence to BUMED shall be forwarded to the cognizant staff officer where applicable.

(3) Sufficient supplies of the necessary blank forms shall be maintained. Forms shall be obtained from the Navy Supply System, unless otherwise directed.

Required Dental Reports

Form No.	Title	To	When	Reference
NAVMED 6600/9	Dental Information Retrieval System Treatment Report (MED 6600-4).	BUMED (orig. only). ¹	Weekly . . .	Art. 6-150.
DD 477-1	Dental Service Report, Equipment and Facilities Supplement (MED 6750-1).	. . . do ^{1,2}	1 January . .	Art. 6-151.
NAVSUP-154	Survey Request, Report and Expenditure (NAVSUP 5040-7).	Retain original in local file. ¹	As required .	NAVSUP Manual vol. II paras. 25155-25167 & vol. III paras. 35041-35050.

¹ Send 1 copy to cognizant staff dental officer.

² Send 1 copy to the Naval Medical Materiel Support Command, 3500 South Broad St., Philadelphia, PA 19145.

6-149. Principal Reports Required From Dental Facilities

(1) The above guide is provided for submitting principal reports required from dental facilities. Training in the preparation of these reports shall be part of the in-service training program.

6-150. Dental Information Retrieval System Treatment Report, NAVMED 6600/9

(1) For instructions on the preparation and submission of the Treatment Report, refer to BUMED-INST 6600.8 series.

6-151. Dental Service Report, Equipment and Facilities Supplement, DD Form 477-1

(1) For instructions on the preparation and submission of the DD 477-1, refer to BUMEDINST 6750.4 series.

6-152. NAVMED 6630/1, Prosthodontic Work Request and Prescription

(1) The NAVMED 6630/1 shall be accomplished for each case processed in a dental prosthetic facility. It shall be retained in the dental activity in an alphabetical file by name of patient until retired in accordance with SECNAVINST 5212.5 series.

6-153. NAVMED 6600/5, Dental Appointments, Daily

(1) *Standard Procedure.*—The following is the standard procedure for using NAVMED 6600/5. Entries may be made with ink or pencil.

(2) *Dental Activities With a Central Appointment Desk.*—Complete the NAVMED 6600/5 at the appointment desk. A rubber stamp may be used to complete ACTIVITY line, which should show the complete address of the activity, station, or ship. The columns TREATMENT ROOM—DATE shall be completed at the appointment desk or in the treatment rooms to which the patients are assigned. Enter patient's name (last, first, and initial), abbreviate grade or rate, and add remarks for local purposes.

(3) *Dental Activities Without a Central Appointment Desk.*—Procedures same as (2) above, with such modifications as may be preferred.

6-155. NAVMED 6630/2, Precious Metal Issue Record

(1) Entries should be made as indicated in appropriate spaces on the NAVMED 6630/2 by activities having prosthetic dental facilities.

(2) The total quantity of precious and special dental metals USED, as computed from the Precious Metal Issue Records, should balance with column 7, CASES DELIVERED, of the Statement and Inventory of Precious and Special Dental Metals (NAVMED 6630/3) and should also balance with the total quantities used for cases delivered, as computed from NAVMED 6630/1, Prosthodontic Work Request and Prescription.

(3) The Precious Metal issue Records, when completed and audited, should be filed in sequence of numbers for cases. They shall be available for inspection at any time until 2 years old, when they shall be destroyed locally.

6-156. NAVMED 6630/3, Statement and Inventory of Precious and Special Dental Metals

(1) NAVMED 6630/3 shall be prepared monthly only by activities having dental prosthetic facilities, in accordance with the following:

(a) *Front of Statement and Inventory.*—

(1) Entries may be typewritten or made by hand with black ink.

(2) ACTIVITY. Name of station, ship, or dental activity in capitals at the left, followed by city, State, or country in capital and small letters, as may be indicated for shore stations; or post office address for ships and foreign shore stations.

(3) Column 3 plus column 4 will be the entry for column 5.

(4) Column 6, MISCELLANEOUS, under EXPENDED. Enter quantities used for technique practice or for metals which may have been lost, etc. Explain on reverse side of form under "Explanation of expenditures of precious and special dental metals from column 6 on other side."

(5) The total for column 6 plus column 7 is subtracted from column 5 and will be the entry for column 8.

(6) The total of columns 9, 10, 11, and 12 is the entry for column 13.

(7) The entries under column 8 and column 13 must be alike.

(8) The dental officer responsible for the precious and special dental metals shall indicate the month and year and sign the STATEMENT.

(9) The personnel of the audit board shall date and sign the INVENTORY.

(b) *Reverse of Form.*—

(1) *Explanation of Expenditures of Precious and Special Dental Metals From Column 6 on Other Side.*—Explain in detail the entries under column 6 on the front of the form.

(2) *Comment and Recommendation by Audit Board.*—It is the responsibility of the audit board to make recommendations for improving the accounting methods. The board may make any other comment considered pertinent.

(c) *Instructions.*—

(1) The original NAVMED's 6630/3 shall be filed in monthly sequence in the dental activity record files. They shall be available for inspection at any time until disposed of in accordance with SECNAVINST 5212.5 series.

(2) Copies shall not be sent to BUMED.

(3) The total quantity of precious and special dental metals USED, as computed from the Precious Metal Issue Records, should balance with the totals of column 7, CASES DELIVERED, in the NAVMED 6630/3.

(4) Precious and special dental metals carried in the Navy Stock Account shall not be taken up on the NAVMED 6630/3.

6-157. Audit Board for Precious and Special Dental Metals

(1) The audit board for the NAVMED 6630/3, Statement and Inventory of Precious and Special Dental Metals, shall consist of three members, appointed by the commanding officer from among those on duty in the activity or facility. The members shall include at least one commissioned officer (a dental officer, whenever possible) and two other members who may be commissioned officers or master/senior chief petty officers. The dental officer charged with the custody of the precious or special dental metals shall not be a member of the audit board.

(2) The dental officer charged with the custody of precious and special dental metals shall prepare the STATEMENT, INVENTORY, and EXPLANATION portions of the NAVMED 6630/3 in advance of the meeting of the audit board.

(3) The audit board shall:

(a) Audit all records related to procurement, receipt, use, and disposition of precious and special dental metals.

(b) Make a physical inventory of all precious and special dental metals in the dental activity.

(c) Reconcile the audit of the records and the inventory with the NAVMED 6630/3 submitted by the dental officer.

(d) Make any pertinent comment or recommendation on the reverse of the NAVMED 6630/3.

(e) Date, sign, and submit the NAVMED 6630/3 to the commanding officer for approval.

6-157A. Dental Health Questionnaire, NAVMED 6600/3

(1) A NAVMED 6600/3 shall be filled out by/for each patient and reviewed and signed by the dental officer who conducts the first subsequent examination or who renders dental treatment. Thereafter, each examining dental officer or dental officer rendering treatment shall indicate, by signature, in the "Routing/Treatment Plan" section that the questionnaire has been reviewed.

(2) Whenever the NAVMED 6600/3 is in need of renewal or updating, the examining dental officer or the person rendering dental care shall be responsible for updating the current questionnaire or completing a new one.

(3) The initial, and all subsequent Dental Health Questionnaires, shall be maintained in the Dental Folder (DD 722-1) for reference and subsequent use in routing or for treatment plan notations.

6-157B. Navy Periodontal Screening Examination, NAVMED 6600/4

(1) Part I of form NAVMED 6600/4 provides instructions and space for scoring the results of the Navy Periodontal Disease Index examination.

(2) Part II of form NAVMED 6600/4 provides instructions and space for scoring the results of the Navy Plaque Index examination.

(3) The most current form shall be maintained in the Dental Folder (DD 722-1) as part of the dental record until all indicated gingival/periodontal therapy has been accomplished.

6-157C. Privacy Act Statement—Health Care Records, DD Form 2005

(1) Each patient will be afforded the opportunity to read and sign the DD Form 2005 which will be placed in the Dental Folder (DD 722-1). If the patient refuses to sign the Privacy Act Statement, such action will be recorded in the SF 603. Appropriate treatment *shall then be provided* based upon available information.

6-158. Individual Dental Officer—Daily Dental Treatment Record

(1) This is a locally developed format to provide individual dental officers a record of dental procedures and services accomplished daily for the purpose of accumulating data for completion of the NAVMED 6600/9. Whereas each dental activity is unique in the mix of dental procedures provided and the types of dental care professionals providing this care, a locally developed and implemented format should enhance the effectiveness of this procedure. This format is not only a feeder report for the NAVMED 6600/9, but it is also an audit trail of dental care provided.

6-159. Dental Records Retirement

(1) When a ship is decommissioned or an activity is disestablished, all official correspondence and records shall be disposed of in accordance with SECNAVINST 5212.5 series.

(2) When a ship is placed in a reserve status or an activity is placed in an inactive or maintenance status, all official records shall be processed in accordance with SECNAVINST 5212.5 series and other current directives insofar as they apply to dental activities.

Section XXII. DENTAL SUPPLIES AND EQUIPMENT

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6-160. Responsibility

(1) The commanding officers of naval regional dental centers and dental officers of other dental facilities shall be charged with the custodial responsibility for all property assigned or received, and shall ensure that inspections and records are maintained on such property.

6-161. Procurement

(1) Procurement of supplies and equipment must follow the philosophy that if they are required they must be procured as expeditiously as possible to assure maximum responsiveness in support of the assigned mission. All standard and nonstandard supplies and equipment shall be procured in accordance with NAVCOMPT Manual, volume II, chapter 2 and current instructions issued by cognizant authority.

6-162. Supplies and Equipment Accountability

(1) *General.*—Accountability for supplies and equipment is required to ensure that public funds are sufficiently protected and to provide the activity a record of ownership, method of purchase, and location or use.

(2) Supply Records.—

(a) Naval regional dental centers will maintain supply records as requested by NAVSUP Manual, volume II, chapter 4.

(b) Other dental facilities shall maintain supply records as required by the commanding officer.

(3) Plant Property Records.—

(a) Naval regional dental centers shall prepare and maintain plant property records as directed by their appropriate plant property accounting activity identified in NAVCOMPT Manual, volume II, chapter 5.

(b) Other dental facilities shall prepare and maintain plant property records as directed by the commanding officer.

6-163. Disposition

(1) Equipment held in a naval regional dental center or dental department shall not be disposed of unless approved by a survey or authorized by transfer. Surveys of supplies and equipment are conducted within the guidance provided by NAVSUP Manual, volume II, chapter 5. Transfer procedures for supplies and equipment are prescribed in NAV COMPT Manual, volume III, chapter 6.

(2) All precious dental metal scraps, bench grindings, and sweepings of the silver, gold, and platinum group shall be collected and turned over to the officer designated by the commanding officer for disposition in accordance with the procedures contained in the Defense Disposal Manual, DOD 4160.21-M. (DOD 4160.21-M is available from the Commanding Officer, Naval Publications and Forms Center, 5801 Tabor Ave., Phila., PA 19120; stock number 0526-LP-416-0340.)

(3) Any precious metal taken from a patient's mouth shall be given to the patient. Should the patient decline to accept the precious metal, it shall be handled in accordance with current instructions for the disposition of precious metal scrap. An entry of the action taken shall be made in the Dental Record.

6-164. Report of Defective, Unsatisfactory, or Excess Material

(1) Any material found to be defective or unsatisfactory shall be reported as prescribed in BUMED INST 6710.63 series. Excess material shall be reported as prescribed in BUMEDINST 4500.2 series.

6-165. Transfer of Custody

(1) An inventory of plant property, precious and special dental material, narcotics, alcohol, and other controlled drugs will be held on the occasion of transfer of custody from one individual to another. This ensures the individual assuming custody that the items are available for use and continuity of responsibility for the Navy.

(2) The officer receiving custody shall make a complete inventory at the earliest practicable date and, in any event, within 20 days after taking charge and shall, in the event of any shortage, submit a request to the commanding officer for a property survey to balance the records and be relieved of responsibility for the shortage.

(3) The officer receiving custody shall not be relieved of responsibility for custody of equipment or supplies unless discrepancies have been resolved by the commanding officer.

6-166. Transfer Between Activities

(1) Dental supplies and minor equipment transferred to other activities shall be expended and receipted utilizing a properly prepared DD 1149 (Requisition Invoice/Shipping Document), which is capable of being audited.

(2) Plant account equipment transferred to other activities shall be expended and receipted utilizing a properly prepared DD 1149 and submission of inventory cards as required by BUMEDINST 4235.5 series.

6-167. Dental Storeroom

(1) The dental officer of a ship shall take charge of and be responsible for the dental storeroom, keeping custody of the key or assigning custody of that key to a designated representative.

(2) Custody of dental storerooms at other activities is dependent upon the regulations governing the stores account in which the material is carried.

6-168. Custody of Precious and Special Dental Metals

(1) Custodial responsibility for bulk supplies of precious and special dental metals shall be vested in a commissioned officer and all stores of these items shall be maintained in locked storage. Senior dental technicians, or civilian personnel, shall be permitted the custody of small working stocks of precious and special dental metals for further issuance to laboratory use.

(2) All personnel having custody of precious and special dental metals shall ensure that proper protec-

tion and preservation are maintained and accounting procedures are afforded this material in accordance with articles 6-156 and 6-157.

6-169. Control of Narcotics and Other Dangerous Drugs and Chemicals

(1) See chapter 21.

6-170. Issues of Supplies and Equipment

(1) Dental supplies and equipment shall be issued for use on a properly authenticated issue document as prescribed by the commanding officer issuing supplies and equipment. Adequate controls will be established to record the transaction as an expenditure to the receiver.

6-171. Materiel for Naval Reserve Training Centers

(1) The initial outfitting list of dental materiel for Naval Reserve training centers is published in BUMED instructions. Requirements for initial outfitting and replenishment materiel shall be requisitioned from the Navy Supply System by appropriate efforts in the Naval Reserve chain of command.

6-172. Operation, Care, and Maintenance of Property

(1) The responsible officer shall require all cognizant persons to properly discharge their responsibilities in connection with the care, conservation, and maintenance of Government property. All instructions, manuals, wiring diagrams, parts listings, and pictorials received with equipment shall be clearly labeled and retained as long as the equipment is in operation or on the ship or station in an operable status.

(2) A preventive maintenance program will be established at each activity or ship as required by BUMEDINST 6700.36 series. The objective of the program is to have a viable dental equipment maintenance and repair program to ensure optimum equipment condition at minimal expenditure of funds for use in providing dental care in support of both the Navy shore establishment and the Operating Forces.

6-173. Investment Equipment Replacement Program

(1) Dental equipment classified as investment equipment must be programmed and budgeted for in accordance with BUMEDINST 4235.5 series.

Section XXIII. FINANCIAL MANAGEMENT

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6-174. Financial Management

(1) Because of the increased financial complexity of health care organizations, financial viability in many situations depends upon the quality of financial management decision making. Good financial decisions must relate to other areas of management and to the changing nature of health care environment. Since it is the inherent responsibility of health care institutions to provide services of the quality and quantity required by the community it supports, every dental command must develop sound short and long range programs, consistent with its mission and its expected resource availability.

6-175. Budgeting

(1) A budget is an expression in financial terms of a plan for carrying out the organization program objective for a specified period of time. The budget is an instrument of planning, decision making, and subsequent control.

(2) Naval regional dental centers shall prepare their budgets in the format as directed by the Bureau of Medicine and Surgery.

(3) Dental departments not under a naval regional dental center shall submit their budgets as prescribed by the commanding officers.

6-176. Resource Authorization

(1) Resource Authorizations (NAVCOMPT 2168-1, Operation and Maintenance Navy and NAV-

COMPT 372, Other Procurement Navy) are issued to naval regional dental centers by the Bureau of Medicine and Surgery and may contain special instructions. The commanding officer is responsible for administration of the resource authorizations, and responsibility may not be delegated. However, the commanding officer may appoint an allotment administrator who will be guided by the instructions contained in NAVCOMPT manuals, Financial Management of Resources (NAVSO P-3006-1), and Financial Management Handbook (NAV MED P-5020), and directives issued by competent authority.

(2) Operating targets are usually provided to dental departments/services, and those provided the targets must adhere to the guidelines of the commanding officer.

6-177. Cost Accounting System (Regulatory)

(1) A good cost accounting system provides a means to integrate accounting and reporting with programming and budgeting. To be effective, the cost accounting system must provide cost and operating results in an efficient and timely manner if it is to be of value to the various managers.

(2) Naval regional dental centers shall establish a proper cost accounting system utilizing the Financial Management Handbook (NAV MED P-5020).

(3) Dental departments/services shall utilize the cost accounting system established by the commanding officer.

Section XXIV. PLANNING DENTAL FACILITIES

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6-178. Dental Facility Planning

(1) It is essential that the facilities necessary for shore (field) activities to accomplish assigned missions be acquired in a timely manner. Facilities acquisition is normally a long lead time process and includes planning, programming, budgeting, contracting, and construction which may take 5 to 8 years.

(2) Under the Naval Shore Facilities Planning and Programming System, the needs of a shore activity for dental treatment facilities are based upon and derived from the mission, base loading, and the assigned tasks of the activity. This data is converted to quantity and type of facilities necessary to provide dental care. OPNAVINST 11010.1 series prescribes the policy for the Navy Shore Facilities Planning and Programming System. NAVFACINST 11010.44 series outlines the detailed procedures whereby individual facilities are planned and programmed. NAVFAC P-80, Facilities Planning Factor Criteria for Navy and Marine Corps Shore Installations, provides facility planning factors and other planning data for guidance in computing quantitative facility requirements.

6-179. Commanding Officer's Responsibility

(1) The commanding officer of a naval regional dental center is responsible for preparing the Basic Facility Requirement List (BFRL) for the center using the planning factors and criteria in the NAVFAC P-80. The proposed BFRL is submitted to the Commander, Naval Facilities Engineering Command via the appropriate Engineering Field Division, with a copy to BUMED and the area coordinator. The BFRL lists the minimum facilities by category code required by an activity to perform its mission, tasks, and functions and is the reference point for all subsequent actions of the system.

6-180. BUMED Responsibilities

(1) BUMED will define operational requirements and technical criteria applicable to the planning,

design, operation, and maintenance of shore facilities in its area of technical and logistic responsibility and will ensure that adequate dental facilities are included in all planning documents which are developed in support of future programs and requirements. BUMED will maintain planning criteria to assist activities in determining dental facility requirements.

6-181. Naval Facilities Engineering Command (NAVFACENGCOM)

(1) In general, NAVFACENGCOM exercises lead responsibilities for performance of activity item planning, military installation planning, and civil engineering. NAVFACENGCOM will apply operational requirements and technical criteria provided by BUMED to the planning and design of all dental facilities ashore. NAVFACENGCOM will develop the Military Construction Program Objectives, and via the Navy Military Construction Review Board, submit the Annual Military Construction Program to the Chief of Naval Operations. The Chief of Naval Operations will review and approve such programs for further submission to higher authority and the Congress, as appropriate.

6-182. Special Projects

(1) The commanding officer of each naval regional dental center is responsible for correcting deficiencies and improving dental facilities. This includes the necessary alterations, maintenance, repair, and equipment installation. OPNAVINST 11010.20 series outlines the detailed funding responsibilities and required documentation.

6-183. Dental Operating Rooms Ashore

(1) The primary unit of planning for dental facilities is the dental operating room (DOR). Dental operating room requirements for any given activity will be determined by several factors, including projected staffing, personnel to be supported, and mission requirements.

(2) In planning for dental operating rooms at the activity level, refer to the NAVFAC P-80 for instructions to determine DOR requirements.

6-184. Oral Hygiene Treatment Rooms

(1) Oral hygiene treatment rooms are planned according to projected oral hygiene staff. Refer to the NAVFAC P-80 for instructions to determine oral hygiene treatment room requirements.

6-185. Prosthetic Laboratory

(1) A dental prosthetic laboratory may be established at an activity when authorized by BUMED. There are three types of dental prosthetic laboratories which have been developed to facilitate the provision of prosthetic care to the authorized patient population.

(a) *Type 1 (Navy Area Dental Laboratory).*—A dental prosthetic laboratory facility as an entity designated to specifically support other military facilities external to its dental command and may include the following capabilities:

(1) Full-time board certified, board eligible, or trained prosthodontists to supervise quality control; expedite urgent cases; facilitate case or prescription changes, as required; and provide limited direct patient treatment support.

(2) Consultation for uniformed services dental officers.

(3) Continuing education resources for dental officers, dental technicians, and residents or other trainees.

(4) Provide educational bulletins for users, to expedite and facilitate adequate communications and standardize procedures.

(5) User testing of the new prosthetic materials and refinement of techniques.

(6) Provide fixed prosthodontic capability for fixed partial dentures and crown fabrication of all varieties.

(7) Provide removable prosthodontic capability for complete denture fabrication and removable partial denture fabrication.

(8) Provide all metal casting capability.

(9) Provide unique services as required, such as, orthodontic support/appliances; surgical implant appliances; maxillofacial appliances; and teaching models and aids.

(b) *Type 2.*—A base or post dental prosthetic laboratory in place to support that military installation or dental command that may have any or all of the type 1 capabilities but is limited in scope and ability to sustain volume. In general, it will have the following characteristics:

(1) Limited on-the-job dental technician training.

(2) Full denture fabrication.

(3) Partial dental fabrication.

(4) Gold casting.

(5) Optional capabilities (chromic metal casting and/or porcelain/metal fabrication).

(c) *Type 3.*—A clinic or basic dental prosthetic laboratory with intrinsic capability to that facility and essential to the daily practice of dentistry, i.e., where multiple clinics exist on a base or post or within a dental command. Equipment and dental technician capabilities vary and tasks usually include:

(1) Prepare casts and models.

(2) Repair dentures.

(3) Fabricate transitional, temporary, or orthodontic appliances.

(4) Finish dentures.

(5) The design and layout of the laboratory is a local determination based on the number of dental prosthetic technicians to be accommodated. BUMED will maintain planning criteria to assist activities in determining prosthetic laboratory requirements.

6-186. Field Dental Facilities

(1) *Fleet Marine Force.*—Dental battalions are separate force level organizations commanded by an officer of the Dental Corps, U.S. Navy and are composed of Navy dental personnel, Medical Service Corps officers, and enlisted Marines. The force dental battalion is designed to support major Fleet Marine Force units such as divisions, wings, force service support groups, or brigades. They are capable of providing tailored detachments to support smaller FMF units and also combine with other dental battalions to provide maximum dental service support where required. While in garrison, a force dental battalion is considered a tenant of the Marine Corps establishment at which it is located and depends upon dental facilities of the nearest naval regional dental center for operating space, equipment, and supplies. When the dental battalion, or components thereof, deploy, either for combat operations or for training exercises, field dental equipment is utilized.

(2) *Mobile Construction Battalions.*—Dental personnel are assigned to construction battalions. When the battalion is in garrison, the Navy establishment at which it is located provides dental operating space, equipment, and supplies. When the construction battalion or its detachments (units) deploy, the dental personnel accompanying the deployment utilize field equipment.

6-187. Dental Facilities in Ships

(1) Dental spaces in ships are allocated by the Naval Sea Systems Command (NAVSEASYS COM) in accordance with the dental support requirements of the particular type of vessel. The Naval Sea Systems Command, in collaboration with BUMED, establishes the location of the dental department and general plan for the dental spaces.

(2) The Naval Sea Systems Command's publication, General Specifications for Ships of the United States Navy, contains requirements for initially outfitting and equipping dental spaces aboard ships. NAVSEASYSCOM has supply responsibility for material which is permanently attached to the hull structure, such as desks, lavatories, file cabinets, lighting fixtures, and certain items of fixed dental equipment.

(3) NAVSEASYSCOM maintains standard and type drawings for the dental officer's office and department administrative spaces. The designs for dental treatment spaces are worked out between NAVSEASYSCOM and BUMED representatives in planning conferences.

6-188. Ship Alterations

(1) Modification of the dental spaces of ships in commission is accomplished by a ship alteration. In

ships with inadequate dental facilities, it is the responsibility of the dental officer to initiate corrective action by presenting a proposal for alteration to the commanding officer. If the commanding officer concurs in the need for the alteration, the command will submit a request to Naval Sea Systems Command that a ship alteration be issued. NAVSEASYSCOM will refer the request to BUMED for technical review. If the request is approved following final review by NAVSEASYSCOM a ship alteration will be issued. In advance of scheduled overhauls, NAVSEASYSCOM reviews outstanding ship alterations and prepares an authorized list of alterations to be accomplished during the overhaul period.

(2) During alterations to the dental facilities, the dental officer should provide technical advice and assistance as required.

Section XXV. INSPECTION OF DENTAL ACTIVITIES AND FACILITIES

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6-193. Inspection Objectives

(1) Evaluate the effectiveness of the inspected command or activity in the performance of assigned mission, functions, and tasks.

(2) Determine the adequacy as to quantity, quality, and management of resources available to the inspected command or activity in the performance of assigned mission, functions, and tasks.

(3) Evaluate the effect of any deficiencies, in either administration or resources, on the ability of the inspected command or activity to perform its assigned mission, functions, and tasks.

(4) Recommend, via the chain of command, appropriate action to correct deficiencies.

6-194. General Instructions

(1) Dental facilities shall be inspected or visited as follows:

(a) Dental activities under the command of the Chief, Bureau of Medicine and Surgery, shall be inspected biennially by the Inspector General, Dental. Command inspections shall be conducted in accordance with OPNAVINST 5040.7 series and BUMED INST 5040.1 series.

(b) Dental departments of activities not under the command of Chief, Bureau of Medicine and Surgery, shall be inspected by the cognizant staff dental officer or the dental officer ordered to assist the immediate superior in command in conducting the command inspection in accordance with OPNAV INST 5040.7 series.

(c) Marine Corps activities shall normally be inspected or visited biennially by the dental officer on the staff of the Commandant of the Marine Corps and annually by the dental officer on the staff of the Commanding General, Fleet Marine Force, Atlantic or Pacific, as appropriate.

(d) When requested, the Inspector General, Dental, shall assist immediate superiors in command by providing dental technical assistance for conducting a command inspection.

(e) Staff dental officers shall provide technical assistance as requested by the area coordinator or immediate superior in the area coordination review or command inspection.

(f) With the concurrence of immediate superiors in command, the Inspector General, Dental,

shall conduct professional/technical visits to the dental departments of naval shore activities and shore based fleet activities and commands as direct liaison with BUMED concerning technical and professional dental matters and policies of particular interest to the Dental Division.

(g) The Inspector General, Dental, will maintain liaison with the Chief of Naval Operations (NAVINGEN) in all matters concerning inspection of dental activities and facilities.

6-195. Scope of Inspections

(1) *Bureau Commanded Dental Activities.*—Inspection of a dental activity under the command of the Bureau should include, but not be limited to, the following:

(a) *Management and Administration.*—

(1) Performance of the assigned mission.

(2) Organization and organization chart of the activity and internal directives.

(3) Development of procedures to the end that the activity will operate according to a functional plan consistent with the best possible utilization of personnel and available funds.

(4) Cleanliness, sanitation, and appearance of the dental activity.

(5) Internal and external security.

(6) Adequacy of public relations.

(7) Dissemination of information to personnel of the command.

(b) *Personnel.*—

(1) Study of personnel requirements.

(2) Maintenance of discipline and administration of personnel.

(3) Appearance and bearing of military personnel.

(4) Adequacy of military professional and technical training programs (residencies, advanced training, technician training).

(5) General educational facilities for personnel of the command.

(6) Physical education facilities, athletics, and recreational programs.

(7) Indoctrination of newly reported personnel.

(8) Maintenance of personnel records, officer and enlisted.

(c) *Dental Services, Operations, and Readiness.*—

- (1) Adequacy of professional care.
- (2) Professional standards.
- (3) Peacetime operation.
- (4) Disaster and emergency plans.
- (5) Condition of materiel readiness.

(d) *Materiel.*—

(1) Security and custody of Government property, including the security and accountability of precious metals, alcohol, and narcotics.

- (2) Stock levels.
- (3) Condition.

(e) *Facilities.*—

(1) Adequacy and utilization of resources.

(2) Planned changes or modifications to the dental facility.

(f) *Special Interest Items.*—As promulgated by notices and the Surgeon General.

(2) *Dental Service in Medical Centers and Hospitals.*—Inspections of the dental service should include, but not be limited to:

(a) *Management and Administration.*—

(1) Performance of the assigned mission.

(2) Assurance that the maximum effort is placed on dental care and that other activities except essential training are kept to a minimum.

(3) Organization and internal directives of the service.

(4) Cleanliness, sanitation, and appearance of the dental service.

- (5) Internal and external security.

(b) *Personnel.*—

(1) Personnel requirements.

(2) Maintenance of discipline.

(3) Appearance and bearing of military personnel.

(4) Adequacy of the dental intern and residency programs when such are being conducted, and technician training.

(5) Indoctrination of newly reported personnel.

(c) *Dental Services, Operations, and Readiness.*—

- (1) Adequacy of professional care.
- (2) Professional standards.
- (3) Peacetime operation.
- (4) Disaster and emergency plans.
- (5) Condition of materiel readiness.

(d) *Materiel.*—

(1) Security and accountability of precious metals, alcohol, and narcotics.

(2) Adequacy of supply support.

(3) Condition and utilization of materiel.

(e) *Facilities.*—

(1) Adequacy of space assigned to the dental service.

(2) Planned changes or modifications to the dental facility.

(3) *Dental Departments.*—Inspections of dental departments at naval shipyards, air activities, stations, bases, and other activities not under the command of BUMED, should include:

(a) *Management and Administration.*—

(1) Mission and organization.

(2) Location in relation to center of population.

- (3) Records and reports.

(4) Log or journal and department organization and instruction book.

(b) *Personnel.*—

(1) Personnel requirements.

(2) Adequacy of professional and technical training programs.

(c) *Dental Services, Operations, and Readiness.*—

(1) Personnel dependent upon the activity for dental care.

- (2) Adequacy of professional care.

(d) *Materiel.*—

(1) Stock levels.

(2) Security, care, and custody of property, including narcotics and alcohol.

(3) Condition.

(e) *Facilities.*—

(1) Adequacy and utilization of facilities.

(2) Planned changes or modifications to dental facility.

Chapter 7

MEDICAL SERVICE CORPS

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Section I. ESTABLISHMENT

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7-1. Establishing Legislation

(1) The Medical Service Corps was established as a staff corps of the United States Navy on 4 August 1947 by the Army-Navy Medical Service Corps Act of 1947 (34 U.S.C. 30 a-j). This staff corps was created as a component of the Medical Department of the Navy to complement the functions of the Medical and Dental Corps.

(2) This act provides for the corps to consist of such specialties as the Secretary of the Navy considers necessary. The Corps currently consists of officers in health care administration, clinical health care services, clinical support sciences and technology, and the human performance and environmental sciences. All Medical Service Corps specialties are enumerated in

the Navy Officer Manpower and Personnel Classifications Manual (NAVPERS 15839D).

7-2. Mission

(1) As established by Public Law, the Medical Service Corps was created as a component of the Medical Department of the Navy to complement the functions of the Medical and Dental Corps. The Medical Service Corps, as a staff corps of commissioned officers, provides Medical Department support to the Operating Forces, Shore Establishments, and other beneficiaries through clinical, science, and management professions in support of medicine and dentistry.

Section II. ORGANIZATION

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7-3. Chief of the Medical Service Corps

(1) The Chief of the Medical Service Corps is appointed by the Secretary of the Navy, upon the recommendation of the Surgeon General, from officers on the active list of the Navy in the Medical Service Corps holding permanent appointments in grades not below lieutenant commander. The Chief is appointed for a term of not more than 4 years, to serve at the pleasure of the Secretary. Permanent status as a commissioned officer in the Medical Service Corps is not disturbed by appointment as Chief (10 U.S.C. 5130(a)).

(2) The Chief of the Medical Service Corps is responsible to the Chief of the Bureau of Medicine and Surgery via the Assistant Chief for Professional Development for the administration, direction, and coordination of the Medical Service Corps.

7-4. Medical Service Corps Division of BUMED

(1) The Chief of the Medical Service Corps is also the Director of the Medical Service Corps Division, Bureau of Medicine and Surgery. The Division Direc-

tor is responsible for the performance of all functions of the Division. The Division plans, advises, and makes recommendations regarding changes in administrative policy related to Medical Service Corps functions; promotes and makes recommendations regarding implementation of professional standards for clinical practice; develops, coordinates, evaluates, and advises on matters pertaining to personnel policy, military requirements, and professional qualifications of Medical Service Corps officers; makes recommendations to the Naval Military Personnel Command regarding procurement, distribution, separation, training, career development, and accounting of Medical Service Corps personnel; and implements policies of the Chief, BUMED, as they relate to clinical practice, service, education, and research.

(2) The Medical Service Corps Division consists of an office of the Division Director, Deputy Director for Health Care Administration, Deputy Director for Health Care and Science, the Career Planning Programs and Requirements Branch which includes the Procurement Programs Section, and specialty advisors.

Section III. MEDICAL SERVICE CORPS OFFICERS

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7-5. Grades and Strength

(1) The Medical Service Corps consists of officers in the grades of ensign through captain. These officers take precedence after officers of the Dental Corps serving in the same grade and having the same dates of rank (10 U.S.C. 5508).

(2) The total authorized number of Regular officers of the corps is limited by law (10 U.S.C. 5404). The authorized active duty strength of the corps, including Regular, Reserve, and temporary officers, is adjusted periodically as required.

(3) Within the authorized strength of the corps, the actual strength of each of the component sections

is contingent on, and determined by, requirements for officers in the specialties concerned.

7-6. Appointments

(1) The general and specific requirements for appointment are set forth in BUPERSMAN, BUPERS Instructions in the 1120 series, and in Navy Recruiting Command Instruction 1110.1 series. Requirements vary with the specific programs, with the sections of the corps in which appointments are sought, and with the status of the candidates.

Section IV. DUTIES OF THE MEDICAL SERVICE CORPS OFFICER

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7-7. General Duties

(1) Medical Service Corps officers render support to the Medical Department by performing primary duties in administration, clinical, and scientific specialties related to health care, safety, and performance effectiveness of naval personnel. In addition to the primary duties prescribed for the billet to which a Medical Service Corps officer is detailed, additional duties which contribute to the proper functioning of the command, and for which the officer is qualified, may also be assigned.

(2) An officer of the Medical Service Corps may be detailed as commanding officer or officer in charge of such activities as appropriate to this corps (10 U.S.C. 5945).

7-8. Off-Duty Employment (Regulatory)

(1) Officers of the Medical Service Corps shall comply with MANMED article 1-22 with regard to off-duty remunerative professional employment.

8

NURSE CORPS

Chapter 8

NURSE CORPS

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Section I. ESTABLISHMENT

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8-1. Establishing Legislation

(1) The Nurse Corps was created by an Act of Congress on May 13, 1908 (35 Stat. 146). The present Nurse Corps, a component of the Medical Department, was established as a staff corps of the Navy by the Act of April 16, 1947 (as revised and reenacted 10 U.S.C. 6027).

8-2. Mission

(1) The primary mission of the Navy Nurse Corps is to provide professional nursing care to, and promote the health of, uniformed service personnel, their dependents, and others as authorized by law. In addition, the Nurse Corps provides instruction and supervision of Hospital Corps personnel in the theory and practice of providing nursing care to patients.

Section II. ORGANIZATION

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8-3. Director, Navy Nurse Corps

(1) The Director of the Navy Nurse Corps is appointed by the Secretary of the Navy upon the recommendation of the Surgeon General from among the officers on the active list of the Navy in the Nurse Corps holding permanent appointments of lieutenant commander and above. The grade of the Director will be determined by the Secretary of the Navy and the term will not exceed 4 years. The Director's permanent status as a commissioned officer in the Nurse Corps is not disturbed by appointment as Director (10 U.S.C. 5140).

(2) The Director of the Navy Nurse Corps is responsible to the Chief of the Bureau of Medicine and Surgery via the Assistant Chief for Professional Development for the administration, direction, and coordination of the Navy Nurse Corps.

8-4. Nurse Corps Division of BUMED

(1) The Director of the Navy Nurse Corps is also the Director of the Nurse Corps Division, Bureau of Medicine and Surgery. The Division Director is responsible for the performance of all functions of the Division. The Division plans, advises, and makes recommendations regarding changes in administrative policy related to nursing; promotes and makes recommendations regarding implementation of professional standards for nursing practice; develops, coordinates, evaluates, and advises on matters pertaining to personnel policy, military requirements, and professional qualifications of Nurse Corps officers and other nursing service personnel; makes recommendations to the Naval Military Personnel Command regarding procurement, distribution, separation, training, career development, and accounting of nursing service personnel; and implements policies of the Chief, BUMED, as they relate to nursing practice, service, education, and research.

(2) The Nurse Corps Division consists of an office of the Division Director, Deputy Director, Executive Assistant, Professional Nursing Branch, Human Resources Inventory and Accounting Branch, and Specialty Advisor(s).

8-5. Other Nurse Corps Positions

(1) The following Nurse Corps officers serve as liaison officers to the Division Director.

(a) Nurse Corps officers assigned to the Naval Military Personnel Command are responsible to the Commander, Naval Military Personnel Command. They act as liaison officers to the Nurse Corps Division, BUMED for coordinating personnel actions related to assignment, distribution, retirement, recall, and release from active duty.

(b) The Nurse Corps officer assigned as the Health Care Planner is responsible to the Director, Resource Planning and Analysis Division and functions as an integral part of that division to investigate, review, analyze, evaluate, and make recommendations related to innovations in the health care system.

(c) The Inspector General, Medical, Assistant for Nursing is directly responsible to the Inspector General, Medical, and evaluates the accomplishment of nursing activities in meeting the goals and objectives of providing the highest quality nursing care; determines if nursing service standards established by professional nursing organizations and hospital accreditation agencies are being met; ascertains compliance with BUMED instructions as they relate to patient care and safety; evaluates the physical and social environment of patients and personnel and identifies hazardous conditions; determines the adequacy of nursing personnel, supplies, and equipment, and evaluates the effect of noted deficiencies in accomplishing patient care objectives; and makes recommendations and suggestions to assist nursing activities to promote and maintain the highest standards of patient care and nursing practice.

(d) The Director, Nurse Corps Programs is assigned to the Naval Health Sciences Education and Training Command and is responsible to the commanding officer. The officer plans, coordinates, administers, and evaluates education and training programs for Nurse Corps officers to meet operational requirements determined by the Bureau of Medicine and Surgery.

(e) The Head of the Nurse Corps Anesthesia School is responsible to the Commanding Officer, Naval School of Health Sciences for the implementation of administrative policies and the management, supervision, and coordination of all phases of training and education for nurse anesthetists.

(f) The Nurse Corps officer assigned to the Operational Medicine Department of the Naval Health Sciences Education and Training Command is responsible to the commanding officer via the head of

that department for assisting in the planning, coordinating, and managing of designated training programs in operational medicine for officer and enlisted personnel of the Medical Department.

(g) Nurse Corps officers assigned to the Instructional Programs Division are responsible to the Commanding Officer, Naval Health Sciences Education and Training Command via their respective department heads. Duties include the development, review, evaluation, and updating of instructional program objectives and standards for Medical Department education and training.

(h) The Nurse Corps officer assigned to the BUMED Quality Assurance Division is the Head of the Standards Development Branch and is directly

responsible to the Director, Quality Assurance Division. Major duties include developing and recommending optimal achievable standards and programs which are designed to increase the quality of care at all levels within the Navy health care delivery system.

(i) Nurse Corps officers assigned to research and special projects are responsible for the administration and coordination of resource planning; initiating and conducting research projects and studies in clinical nursing, nursing education, and nursing administration designed to improve the delivery of patient care services; interpreting and reporting research findings; and for making recommendations for improvement of nursing practice and development of nursing service personnel based on these findings.

Section III. NURSE CORPS OFFICERS

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8-6. Grades and Strength

(1) The authorized number of Regular officers of the Nurse Corps is 6/10 of 1 percent of all authorized commissioned officers, enlisted personnel, midshipmen, and the actual number of warrant officers of the Regular Navy and Regular Marine Corps (10 U.S.C. 5404).

(2) The Nurse Corps consists of officers in the grade of ensign through rear admiral.

8-7. Appointments

(1) Initial appointments in the Nurse Corps, Naval Reserve, are made in the grades of ensign, lieutenant (junior grade), and lieutenant depending upon the professional and personal qualifications of the applicant as outlined in the MILPERSMAN 1020100 and the Navy Officer Recruiting Manual (COMNAVCRUITCOMINST 1110.1 series).

8-8. Promotions

(1) *Eligibility.* — Nurse Corps officers are eligible for consideration for promotion to the next higher grade when in the promotion eligibility zone. (Title 10 U.S.C. 5753 as amended by Public Law 90-130 of 8 November 1967.)

(2) Qualifications —

(a) Nurse Corps ensigns are promoted to lieutenant (junior grade) upon the promulgation of the promotion authority by the Secretary of the Navy and upon the commanding officer's recommendation that the officer is mentally, physically, morally, and professionally qualified in accordance with title 10 U.S.C. 5784 (male) and title 10 U.S.C. 5787B (female). Promotion usually occurs on the second year anniversary of the date of grade as ensign.

(b) Promotions to lieutenant, lieutenant commander, commander, and captain are made upon the recommendations of a selection board convened for each grade. Each Nurse Corps officer is selected for promotion in competition with other Nurse Corps officers of the same grade on the basis

of performance as reported in the Fitness of Officers report.

8-8A. Registration Requirement (Regulatory)

(1) All Nurse Corps officers, Regular and Reserve, are required to maintain an active, current registration or license as a professional nurse in a state, the District of Columbia, the Commonwealth of Puerto Rico, or a territory of the United States.

8-9. Retention on Active Duty

(1) Reserve Nurse Corps officers may remain on active duty beyond their minimum required service by submitting a request for augmentation and/or extension of active duty.

(a) *Augmentation.* — Nurse Corps officers of the Naval Reserve may apply for augmentation into the Regular Navy. Applicants must meet the requirements as set forth in the MILPERSMAN 1020120. A request for resignation of an officer of the Regular Navy will normally not be accepted for a period of 2 years following acceptance of an appointment in the Regular Navy.

(b) *Extension of Active Duty.* — Nurse Corps officers of the Naval Reserve may request voluntary extension of active duty of definite or indefinite duration. Extensions for periods of less than 12 months normally will not be granted unless unusual circumstances prevail. Requests should be submitted in accordance with MILPERSMAN 1030150.

8-10. Release from Active Duty

(1) The Naval Military Personnel Command assignment officers are responsible for initiating action for the voluntary release of Reserve officers upon completion of their active obligated service. Requests received from Reserve officers who desire early release or release from indefinite extension of active duty are processed in accordance with MILPERSMAN 3830100 and 3820130 respectively. Action on requests for early release of Reserve officers is considered by a board convened by the Naval Military Personnel Command.

(2) The involuntary release of Reserve officers is provided for in MILPERSMAN 3830110 and SEC NAVINST 1920.6 series.

8-11. Resignation

(1) Officers of the Regular Navy and the Naval Reserve serving on active duty who submit a request for resignation and have fulfilled the service requirements of SECNAVINST 1920.6 series may expect favorable action providing for release from active duty.

8-12. Retirement

(1) *Voluntary Retirement, Regulars.* —

(a) SECNAVINST 1811.3 series sets forth the policy concerning retirement of commissioned officers with 20 or more years of active service. Requests for retirement from members with 20 or more years of active service will be considered on the basis of the overall needs of the service and the merits of the individual request.

(b) Final approval of request for retirement rests with the Secretary of the Navy. Approval of requests will normally be withheld until the individual has completed a minimum of 1 year at the current duty station, or a normal tour when serving outside the contiguous United States.

(2) *Statutory Service Retirement, Regular (MILPERSMAN 3860100) (Captain and Commander, 10 U.S.C. 6377; and Lieutenant Commander, 10 U.S.C. 6396).* —

(a) A Nurse Corps officer on the active list of the Navy with a permanent appointment in the

grade of captain shall be retired by the President on the first day of the month following the month in which the officer completes 31 years of active commissioned service.

(b) A Nurse Corps officer on the active list of the Navy with permanent appointment in the grade of commander who is not on a promotion list to captain and is considered as having twice failed selection shall be retired by the President on the first day of the month following the month in which the officer completes 26 years of active commissioned service.

(c) An officer on the active list of the Navy in the grade of lieutenant commander in the Nurse Corps shall be retired on 30 June of the fiscal year in which the officer (1) is not on a promotion list, (2) is considered as having twice failed selection for promotion to the grade of commander, and (3) has completed at least 20 years of active commissioned service.

(3) *Retirement, Reserve Officers.* — MILPERSMAN 3830110 contains the basic regulations concerning retirement of Reserve officers. Nurse Corps officers of the Naval Reserve may be retired with pay at any time upon request after 20 years of active service in the Armed Forces. SEC NAVINST 1920.6 series contains the pertinent administrative policy and information for the involuntary release to inactive duty of Reserve officers. In general they are released from active duty on 30 June of the year in which they attain retirement eligibility.

(4) *Physical Disability Retirement, Reserves, and Regular Officers.* — MILPERSMAN 3860340 contains the basic regulations relative to retirement as a result of physical disability.

Section IV. DUTIES OF THE NURSE CORPS OFFICER

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Charge Nurse	8-18
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Anesthetists	8-20
School Instructors	8-21
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8-13. Duty Assignments, General

(1) Assignments are made to medical facilities where authorized billets exist for Nurse Corps officers.

(2) All assignments are made in accordance with the needs of the service, the professional qualifications, and, if feasible, the personal preference of the Nurse Corps officer.

8-14. Director, Nursing Service

(1) The director of nursing service and senior Nurse Corps officers in charge of nursing service shall be responsible to their commanding officers or seniors in the chain-of-command for all nursing service provided by the command to which attached. These officers carry ultimate administrative authority and responsibility for planning, directing, coordinating, and evaluating activities of the nursing service. As a member of the administrative staff, the director participates in formulating hospital policy, in devising procedures essential to the achievement of objectives, and in developing and evaluating programs and services. The nature of the position implies accountability for creating a system which fosters the participation of nursing staff in planning, implementing, and evaluating practice to ensure safe, efficient, and therapeutically effective nursing care.

8-15. Educational Coordinator

(1) The responsibilities of the educational coordinator are to plan, organize, direct, coordinate, evaluate, and document the inservice program of the nursing service. Inservice education is a planned educational experience provided in the job setting, closely identified with service, and designed to promote personal and professional achievement. Staff development programs utilize educational resources inside and outside of the hospital setting.

8-16. Patient Care Coordinator

(1) The primary responsibility of the patient care coordinator is to ensure that nursing service personnel provide safe, efficient, and therapeutically effective patient care. To accomplish this function, the coordinator organizes, directs, supervises, counsels, instructs, and appraises the performance of nursing service personnel in planning, providing, and evaluating nursing care based on the needs and responses of patients and considering the preparation and experience of available staff. The coordinator collaborates with appropriate representatives of other services, disciplines, and agencies to improve the quality and quantity of services rendered and to maintain the highest professional standard of care.

8-17. Clinical Consultant

(1) The clinical consultant provides highly skilled, specialized nursing care and is responsible for the following: coordinating the orientation of newly assigned nursing service personnel; developing and planning new approaches to nursing care; providing assistance and consultation to nursing staff in solving complex patient care problems; conducting specialized clinical teaching on both a formal and informal basis; participating in an interdisciplinary approach to patient care; and conducting research and evaluating current methods and practices.

8-18. Charge Nurse

(1) The charge nurse is responsible for the administration of nursing service in a designated patient care area. The charge nurse ensures quality care utilizing professional knowledge and clinical expertise in assessing, planning, providing, directing, and documenting all nursing activities. In addition, the charge nurse establishes and coordinates educational and guidance programs for patients and nursing service

personnel; assigns duties for each staff member recognizing experience and professional competence; supervises and evaluates work performance; ensures proper environment for patients and personnel; and assists in research or special projects as assigned.

8-19. Nurse Practitioners

(1) The primary function of the nurse practitioner is to provide health care services for patients in the primary care setting. To accomplish this clinical function, the nurse practitioner utilizes first entry into the health care system as a contact point for assuming on-going responsibility and accountability for the patient in health maintenance, treatment, and prevention of illness. Although the nurse practitioner serves in a collaborative role with the physician, the officer is directly responsible to the director, nursing service for administrative purposes.

8-20. Anesthetists

(1) The primary function of the certified registered nurse anesthetist is to provide medically delegated services to patients requiring anesthetic care. To accomplish this function, the anesthetist is responsible to the patient and physician for those services performed, under the direction of the chief of anesthesia (or chief of surgery if in a duty situation without an anesthesiologist); and is responsible to the director of nursing services for administrative purposes in those functions and policies that are related to nursing services.

8-21. School Instructors

(1) *Naval Education and Training Center, Newport, RI.*—A selected number of Nurse Corps offi-

cers are assigned as instructors for the Officer Indoc-trination School and are responsible for providing newly commissioned officers with a comprehensive orientation to the Navy and the Medical Department.

(2) *Class A school.*—Nurse Corps officers are assigned as instructors in principles and techniques of patient care and provide classroom and clinical learning experience for student Hospital Corps personnel.

(3) *Class C schools.*—Nurse Corps officers are assigned to various medical facilities and are responsible for providing instruction to Hospital Corps personnel in medical technician specialties.

(4) *Anesthesia school.*—Nurse Corps officer anesthetists assigned to the Naval School of Health Sciences function as instructors in orientation to, and methods and techniques of, anesthesia. In conjunction with the anesthesia school, Nurse Corps officer anesthetists are assigned to BUMED designated naval regional medical centers as instructors to provide supervision and guidance for students during the second year of anesthesia school.

(5) *Other.*—Nurse Corps officers are assigned to other BUMED designated facilities as instructors in specialized clinical nursing courses.

8-22. Recruiting

(1) The Navy Nurse Programs officers are responsible for recruiting qualified applicants for direct appointment in the Navy Nurse Corps. Methods of recruiting include presentations in colleges and universities and to various civic, educational, and professional groups. The Navy Nurse Programs officer represents the Navy Nurse Corps to the nursing community as well as to the general public through various communication media.

Note: There is no article 8-23.

Section V. MANAGEMENT AND ADMINISTRATION

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Subspecialty Codes	8-26
Publication of Professional Articles	8-27
Participation in Professional Organizations	8-28
Off-Duty Employment (Regulatory)	8-29

8-24. Utilization of Nursing Personnel

(1) Pertinent parts of DOD Directive 1125.1 of 16 September 1967 are quoted for information and compliance:

I. REISSUANCE AND PURPOSE. This Directive . . . sets(s) forth current policy with regard to utilization of military and civilian nursing personnel by the armed forces and to clarify working relationships of various categories of nursing personnel.

III. POLICY. It is the policy of the Department of Defense that:

A. Professional, technical, and vocational nurses and other categories of auxiliary personnel required to provide nursing services will be included in an identifiable division, department, or equivalent unit at each appropriate level within the organization of the respective military departments.

B. Each such division, department, or equivalent nursing unit will be supervised and administered by a professional nurse of appropriate experience and seniority with the necessary authority to ensure effective and efficient management of nursing services.

C. Professional nurses will also function as supervisors of technical and vocational nurses in the provision of nursing services.

D. Personnel engaged in providing nursing services normally shall be utilized in the performance of nursing assignments only. This policy may be waived in areas where conditions are such as to require all personnel with the armed forces be available for general assignments.

8-25. Civilian Nursing Service Personnel

(1) Employment of civilian personnel for nursing service will be in accordance with appropriate provi-

sions of the Federal Personnel Manual, Navy Civilian Manpower Management instructions, and the Manual of the Medical Department.

8-26. Subspecialty Codes

(1) The Nurse Corps is utilizing subspecialty coding to identify billets in which a doctoral, a masters, or a baccalaureate level of education, or specialized training or experience is essential for optimum performance of duty. The guidelines and criteria for subspecialty coding are in BUMEDINST 1211.1 series.

8-27. Publication of Professional Articles

(1) Nurse Corps officers are encouraged to make contributions to both military and civilian professional literature. They shall be guided by Navy Regulations and current directives relative to preparation and submission of articles for publication.

8-28. Participation in Professional Organizations

(1) It is strongly recommended that Nurse Corps officers maintain membership and participate in the official organizations of the nursing profession. Nurse Corps officers are also encouraged to be participating members in other professional organizations.

8-29. Off-Duty Employment (Regulatory)

(1) Officers in the Nurse Corps shall comply with article 1-22 as regards off-duty remunerative professional employment.

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Chapter 9

HOSPITAL CORPS

Sections

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Section I. STRUCTURE OF THE HOSPITAL CORPS

	Article
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Rate and Rating Structure	9-3
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9-1. Establishment

(1) The Hospital Corps as it is now known was established within the Medical Department of the Navy under the provisions of an act of Congress approved 17 June 1898 (ch. 463, sec. 1, 30 Stat. 474).

9-2. Strength

(1) The strength of the Hospital Corps is determined by the Chief of Naval Personnel within personnel allocations authorized by the Chief of Naval Operations, who implements the statutory restriction on total Hospital Corps strength. (10 U.S.C. 5412.)

9-3. Rate and Rating Structure

(1) A rate identifies personnel occupationally by pay grade. Within a rating, a rate reflects levels of aptitudes, training, experience, knowledge, skill and responsibility. The rating of hospital corpsman is comprised of rates as follows:

Rate	Rate abbreviation	Pay grade
Hospital recruit	HR	E-1
Hospital apprentice	HA	E-2

Rate	Rate abbreviation	Pay grade
Hospitalman	HN	E-3
Hospital corpsman, third class	HM3	E-4
Hospital corpsman, second class	HM2	E-5
Hospital corpsman, first class	HM1	E-6
Chief hospital corpsman	HMC	E-7
Senior chief hospital corpsman	HMCS	E-8
Master chief hospital corpsman	HMCM	E-9

(2) Rating is a term used in the Navy to identify an occupational specialty which encompasses related aptitudes, training experience, knowledge and skills. For example, the rating "hospital corpsman" comprises training and experience in the care of the sick and injured.

9-4. Navy Enlisted Classification (NEC) Structure

(1) The NAVPERS 18068D, section II, Manual of Navy Enlisted Manpower and Personnel Classifications and Occupational Standards, contains the enlisted classification coding structure and is the primary tool for the NEC coding of manpower authorization and personnel.

(2) The Chief of Naval Personnel is responsible for the formulation and implementation of the NEC coding system, control of the use of NEC's in identifying personnel and billets, and in distribution and detailing of personnel. But BUPERS delegates certain related authorities and responsibilities to the Bureau of Medicine and Surgery for the assignment of NEC codes in the HM-8400 and HM-8500 series. Once such an NEC is assigned, it may not be revoked or changed without specific authority from the Chief, Bureau of Medicine and Surgery.

(3) Upon being selected for advancement in rate to hospital corpsman, first class, personnel holding NEC codes shall be subject to the classification procedures outlined in BUMEDINST 1510.10 series.

(4) The NEC's shall be reviewed and verified to insure accuracy and currency upon detachment, receipt, annual service record verification, separation, discharge, reenlistment, transfer to the Fleet Reserve, or retirement.

(5) Rate and NEC requirements for each command are authorized by the Chief of Naval Operations and published in the form OPNAV 1000/2, Manpower Authorization. Commanding officers should request modifications of their Manpower Authorization when changes in workload or mission of the activity dictates modification of their NEC job requirements. Quantitative training requirements for technicians are determined from the NEC's written into the Manpower Authorization. Therefore, careful monitoring of this document is mandatory if these requirements are to be met.

Section II. HOSPITAL CORPS PERSONNEL, GROUP X MEDICAL

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9-5. Qualifications

(1) Applicants for the hospital corps rating should be volunteers, male or female, have demonstrated aptitude and sincere motivation toward care of the sick and injured, have combined General Classification Test plus Arithmetic 105, be in pay grade E-2 or E-3 and have not successfully completed a Class "A" level school, be a high school graduate or have a General Educational Development equivalency certificate, have no history of illicit drug usage, and have 20 months voluntary active-obligated service remaining on course convening date. Waiver of one or more of the above will be considered only under extreme circumstances with ample justification. Applicants should be evaluated by a Classification Interviewer, PN-2612, or by an officer or senior enlisted member (E-6-E-9) of the Medical Department to assist in determining qualifications and motivation.

9-6. Procurement

(1) Candidates for the Hospital Corps are procured from volunteers enlisted directly as hospital recruits, undergoing recruit training selected by the Classification Interviewers (PN-2612) SCORE Program; serving in other ratings "strikers"; and serving in the Marine Corps; and from volunteers in various special programs as outlined in the Navy Recruiting Manual—Enlisted (COMNAVCRUITCOMINST 1130 series).

(2) "Strikers" are enlisted personnel who have been trained, or have demonstrated certain skills, and are serving in general apprenticeships in other ratings at pay grades E-1, E-2, or E-3 and request transfer to the Hospital Corps. Requests for Class "A" Hospital Corps school should be submitted to BUPERS via BUMED (Code 34) on the form NAVPERS 1306/7, Enlisted Transfer and Special Duty Request. Commanding officers shall recommend approval or disapproval, verifying all information and making specific comment to the technical competence of the applicant in his present rate; his academic ability as indicated by educational background and by corre-

spondence course and service records; his potential ability; his general attitude and motivation; and an estimate of the applicant's future value to the naval service. When possible, the report of interview conducted by an officer or senior enlisted member (E-6-E-9) of the Medical Department shall be an enclosure to the forwarding endorsement.

(3) Under regulations prescribed by the Secretary of the Navy, enlisted members of the Marine Corps are eligible for transfer to the Hospital Corps of the Navy, and enlisted members of the Hospital Corps are eligible for transfer to the Marine Corps (10 U.S.C. 6014).

9-7. Distribution and Detail

(1) Hospital Corps personnel may be assigned to any unit or activity of the Naval Establishment where their services are required. They shall be assigned to the medical department of the ship or station to which they are attached. Duties performed by Hospital Corps personnel will be in accordance with the limitations set forth in the 1973 Navy Regulations article 0845. Information relative to duty assignments of Hospital Corps personnel is contained in NAVPERS 15909B, Enlisted Transfer Manual.

(2) Hospital Corps personnel holding a Navy Enlisted Classification Code should be assigned to an activity having a requirement written into its enlisted Manpower Authorization for that NEC at the pay grade held by the Hospital Corps personnel so assigned.

9-8. Duties of Hospital Corps Personnel

(1) The general duties of Hospital Corps personnel are prescribed by the Surgeon General as set forth in this manual and BUMED directives. Duties on any specific ship or station are prescribed by the commanding officer, the senior medical officer, or other competent authority. Hospital Corps personnel shall be assigned only to such duties as allowed by the Geneva Conventions of 1949 and Navy Regulations

article 0845. At times adherence to the provisions may be burdensome but the parties to the Geneva Conventions determine that the protection of medical personnel was important enough to justify such a burden. NAVREGS article 0845 is an amplification with greater specificity of a consistent Navy policy which has been followed since the entry into force of the Geneva Conventions of 1949. All duties of hospital corpsmen must be concerned with care of the sick and injured, the prevention of disease or injury, or the administration of medical departments, divisions, or commands. These duties shall be performed under the supervision of Medical Department officers except for hospital corps personnel serving on independent duty. (See sec. III of this chapter.)

(2) Specific duty assignments should be rotated to provide diversified training and job experience. This rotation should be planned on an individual basis considering the degree of individual adaptability as well as job and training requirements. A careful balance must be maintained between the advantages of increased job efficiency resulting from permanency of personnel and the training advantages derived from rotation. The provisions of BUMEDINST 1510.8 series should be considered in the rotational assignment of personnel.

(3) Hospital Corps personnel should not be required to perform night duty periods in excess of 30 days and should not be assigned night duty more often than 1 month out of 3. Hospital Corps personnel should be granted 48 hours liberty immediately preceding and subsequent to a tour of night duty.

9-9. Duties of the Hospital Corps Rates

(1) *Hospital Recruit (HR)* are now enlistees in the Hospital Corps. Upon completion of basic recruit training they are assigned duty under instruction at a Class "A" basic Hospital Corps school.

(2) *Hospital Apprentice (HA)*.—After graduation from Hospital Corps school, they preferably shall be assigned duties directly relating to patient care. When feasible, they should be assigned to on-the-job training in those areas which involve elementary nursing procedures.

(3) *Hospitalman (HN)* should be assigned in the same manner as a hospital apprentice, to include on-the-job training in direct patient care involving advanced procedures, or assigned to duty and on-the-job training in elementary clinic procedures.

(4) *Hospital Corpsman, Third Class (HM3)* is normally assigned to duties involving direct patient care and to clinical services, for on-the-job training in the more advanced clinical procedures.

(5) *Hospital Corpsman, Second Class (HM2)* may be assigned duty as senior ward corpsman, or as a trained paramedical technician serving in an authorized (HM-8400 or HM-8500) NEC billet in clinics or services providing direct patient care support.

(6) *Additional Duties*.—Duties for hospital apprentices, hospitalmen, hospital corpsmen, third class and hospital corpsmen, second class may also include service with the Operating Forces. When and where possible, personnel in operational billets should be given the opportunity to work in direct patient care at nearby inpatient facilities.

(7) *Hospital Corpsman, First Class (HM1)* may be assigned supervisory duty on wards, as assistant to the chief of a clinical service or within a paramedical specialty (HM-8400 or HM-8500) NEC. Duties may also include assignment as an instructor, service with the Fleet on independent duty, the Fleet Marine Forces, Reserve Training Center, recruiting duty, etc. Normally, assignment to independent duty will be preceded by formal training.

(8) *Chief Hospital Corpsman (HMC)* may be assigned supervisory duties as senior assistant to the chief of a clinical service and other duties including those previously stated in (7) above.

(9) *Senior Chief Hospital Corpsman (HMCS)* serves as supervisory/middle management personnel with primary concern directed toward the HM rating in general or a specialty area in which he or she has expertise based on formal training and experience. Assignments may include duty as the senior hospital corpsman aboard large Fleet Units such as CV's, AD's, AOE's, FMF, etc. Also they may be assigned as instructors within the areas of their technical expertise, and as enlisted medical advisors within medical regions. They may fill administrative billets within and outside their field of expertise which require extensive practical experience as well as advanced theoretical knowledge.

(10) *Master Chief Hospital Corpsman (HMCM)* serves in an advisor or administrator billet within the HM rating. When necessary, they may augment the officer corps in billets as over-all supervisors and administrators of personnel and equipment within their organization. They may fill billets within a technical field when the billet requires exceptional technical expertise plus a high degree of managerial ability. They may also be assigned as medical administrative assistants on the staff of Fleet and Force Commanders, FMF Units, and as advisors or instructors in both basic and advanced training facilities. Although assigned an NEC they may be assigned to medical administrative billets when required by the needs of the service.

9-10. Utilization

(1) The maximum number of Hospital Corps personnel possible shall be assigned to duties involving direct patient care and clinical services, or in paramedical assignments dictated by their Navy Enlisted Classification unless otherwise prohibited by statute or regulation. (See art. 9-8(1).)

(2) The requirement for assigning qualified personnel to patient care is paramount; therefore, all Hospital Corps personnel performing duties in the nursing service shall be assigned en bloc to the nursing service.

(3) Consistent with mission requirements, watches should be equitable for all Hospital Corps personnel in the same rate, with progressively fewer watches being assigned as they advance in rate.

(4) Average work hours should be the same for all Hospital Corps personnel of like rates. The average work week should be no greater than necessary to insure quality patient care.

(5) Hospital Corps personnel should be rotated throughout the various patient care areas, clinics, emergency rooms and recovery areas to assure wide exposure to the various techniques in the care and treatment of the sick and injured.

(6) Hospital Corps personnel who cannot perform effectively in the patient care environment should be recommended for administrative discharge or change in rating as appropriate, rather than arbitrarily reassigning them to nonpatient care functions.

(7) Hospital Corps personnel should not be considered eligible for reassignment from a patient care environment solely because they have completed a certain length of time in that environment or have advanced in rate.

(8) Hospital Corps personnel holding a Navy Enlisted Classification Code and assigned to an activity to fill an allowance for that classification will be utilized in that specialty or their NEC should be removed.

9-11. Training

(1) The Chief, Bureau of Medicine and Surgery is responsible for all training of personnel of the Hospital Corps except general military training which is under the cognizance of the Chief of Naval Education and Training. Training consists of the Class "A" basic Hospital Corps schools, and formal training programs for medical technicians taught in the Class "C" schools. On-the-job training is authorized only as outlined in BUMEDINSTS 1510 series. Training quotas are established annually and reviewed

quarterly to insure that billet revisions authorized by CNO are properly reflected in the training plan. Training quotas represent the number of students required to staff authorized billets at 100 percent, and ideally should negate the need for on-the-job training. On-the-job training of technicians in specialties for which a formal program exists reduces the number of general service personnel available to meet other authorized requirements. It results in improper management of rotation policy which is geared to a fair and equitable distribution of personnel assets between shore and sea duty. It also results in the forced misassignment of technicians to meet operational requirements.

(2) *Class "A" Basic Hospital Corps Schools* mission is to instruct and train enlisted personnel in the basic subjects and procedures required to qualify them for duties as general service Hospital Corps personnel. The curriculum emphasizes direct patient care and is designed to prepare the student to perform the general duties normally required of Hospital Corps personnel during their first enlistment in the naval service. This school, together with the subsequent inservice training which they will receive, is designed to prepare all Hospital Corps personnel for advancement in rate through third class. Class "A" Hospital Corps school is mandatory for all personnel entering the Hospital Corps or first reporting to active duty in the hospital corps rating if comparable training has not previously been completed. Upon completion of this course of instruction appropriate entries will be made in the service record and a training certificate issued.

(3) *Formal Inservice Training, Class "C" Schools.*—Formal training courses for Hospital Corps personnel are listed in the NAVEDTRA 10500, volume IX, Catalog of Navy Training Courses (CANTRAC), which provides data on the purpose, scope, prerequisites, location, and convening dates of the courses. Requests for training should be submitted to BUPERS via BUMED (Code 34) on a NAVPERS 1306/7. Selection of candidates for training is a competitive process and includes a comprehensive review of each candidate's potential. Candidates should consider the career pathways for Hospital Corps personnel when applying for training (BUMEDINST 1510.10 series). Personnel volunteering for duty with Fleet Marine Force may do so by requesting assignment to a field medical service school. Personnel earning an NEC as a result of formal training will be designated in the Naval Manpower Information System automatically through the Navy Integrated Training System or by BUMED if indicated in accordance with NAVPERS 18068D, section II, Manual of Navy Enlisted Manpower and Personnel Classifications and Occupational Standards. If selected for Class "C" training, candidates are ordered to duty under instruction at the time of sea or shore rotation to the

extent feasible. Upon successful completion of technical training a Certificate of Special Instruction will be issued and appropriate entries made in the service record.

(4) *Inservice Training.*—The inservice training program, including lesson plans and on-the-job training guides, shall be developed utilizing the “knowledge” and “practical factors” requirements established in NAVPERS 18068D, section I, Qualifications for Advancement in Rating for each pay grade in the Group X, HM rating. The inservice training program for each rate should be developed locally, and should be monitored by the education and training officer to determine that instruction, formal and on-the-job, is being assimilated by the trainee. Periodic examinations should be administered and, where feasible, tied in with recommendations for advancement in rate for the member concerned. Commanding officers shall designate an officer of the Medical Department, or the Medical Department representative, as the education and training officer for this program. This officer shall be directly responsible to the commanding officer for the development, organization, administration, and direct supervision of the inservice program, and shall consult with the commanding officer on a regular basis concerning the status, success, and requirements of the program. An officer of the Nurse Corps, if available, should be appointed to assist the education and training officer in the development, implementation, and supervision of all phases of the inservice training program devoted to nursing subjects. BUMEDINST 1510.8 series is a guideline for development and implementation of the inservice program.

(5) *Part-time Outservice Training.*—The Bureau encourages Hospital Corps personnel to take advantage of part-time outservice training in accredited civilian institutions and will authorize tuition aid, provided funds are available, for courses directly related to areas of Medical Department responsibility. Such areas are considered to be physical, chemical, clinical, biological, and sociopsychology sciences and the fields of Medical Department administration. Consideration will also be given to requests for other courses if they are a necessary part (required credits or prerequisites to desired courses) of a fully planned program leading to a degree or certificate which will enable the applicant to assume increased responsibility or to function more effectively. Members of the hospital corps rating who upon initial entry into the part-time outservice training program request courses not directly related to areas of Medical Department responsibility may be considered if they are taking a course relating to one of the professional improvement programs leading to a commissioned officer grade. Accredited institutions of higher education are those listed in the latest U.S. Office of Education's *Educational Directory, Part III, Higher Edu-*

cation. Certain high school and college courses may be considered as accredited at the discretion of Naval Health Sciences Education and Training Command, Bethesda, MD. To be eligible to participate, personnel must be members of the Hospital Corps on active duty, either in the Regular Navy or the Naval Reserve. Hospital Corps personnel must have sufficient obligated service remaining to insure completion of courses requested. Information concerning requirements and administrative procedures for the part-time outservice training program are listed in BUMEDINST 1500.7 series.

9-12. Advancement in Rate

(1) The objective of the enlisted advancement system is to furnish the qualified petty officers that the Navy requires to man its ships and stations. Such advancements in turn provide the opportunity for orderly advancements of qualified enlisted personnel to higher levels of responsibility throughout their naval careers.

(2) The Manual of Advancement (BUPERSINST 1430.16 series) provides for the administration of the advancement in rate system. To further supplement the advancement policies and procedures, BUPERS notices are promulgated semiannually.

(3) Examinations are prepared by the Naval Examining Center based on the qualifications outlined for each rate in the Manual of Qualifications for Advancement (NAVPERS 18068D). The NAVEDTRA 10052, Bibliography for Advancement Study lists the training courses and study guides applicable to each rating in the Navy. These publications (Bibliography for Advancement Study, manuals, study guides, Handbook of the Hospital Corps, etc.) serve as a working list of materials for personnel to study in preparing for advancement and are also the source documents for questions used in the Navy-wide advancement examinations.

(4) To be eligible for advancement in rate Hospital Corps personnel must fulfill service requirements, both time in service and time in pay grade, complete required Navy training courses, complete required practical factors, meet performance mark requirements, be recommended by commanding officer, and successfully pass the required military/leadership examination.

(5) Hospital Corps personnel with NEC codes assigned take the same military and professional examinations as their contemporaries who are not technicians. For this reason and because technicians may be called upon at any time to perform the general duties of their rate, technicians must maintain professional competence in the general duties of the Hospital Corps as published in NAVPERS 18068D, Manual of Qualifications for Advancement.

9-13. Path of Advancement to Officer Status

(1) Hospital Corps personnel may apply for commissions in the programs listed below provided they meet all eligibility requirements:

(a) Officer Candidate School Program (BUPERSINST 1120.35 series)

(b) U.S. Naval Academy (BUPERSMAN 1020220)

(c) Warrant Officer (BUPERSMAN 1020310)

(d) Navy Enlisted Dietetic Education Program (BUPERSINST 1120.38 series)

(e) Naval Enlisted Scientific Education Program (BUPERSMAN 1020350)

(f) Medical Service Corps (BUPERSINST 1120.15 series)

(g) Warrant Officer (Physician's Assistant) (BUPERSMAN 1020315)

9-14. Availability of Form

(1) The form NAVPERS 1306/7, Enlisted Transfer and Special Duty Request, cited herein is available from the cognizance "I" forms and publications supply distribution points.

Section III. HOSPITAL CORPS PERSONNEL ON INDEPENDENT DUTY (MEDICAL DEPARTMENT REPRESENTATIVE)

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9-15. Qualifications

(1) All personnel in pay grades E-6 through E-9 are considered eligible for duty independent of a medical officer unless prohibited by statute or regulation. Normally, assignment to duty independent of a medical officer is preceded by formal training. When personnel in these grades are not available, hospital corpsmen, second class, who have been trained as advanced hospital corpsmen or submarine medical technicians may be assigned to duty independent of a medical officer. Personnel who have not served in a billet independent of a medical officer for a 3-year period will be required to successfully complete surface refresher training or submarine clinical refresher training depending on the nature of their assignment. While serving in duty independent of a medical officer, they will have the title, Medical Department representative (MDR).

9-16. Responsibilities

(1) The Medical Department representative serves as the representative of the Surgeon General in all medical functions performed on independent duty and is directly responsible to the commanding officer for the health of the crew; sanitation of the command; care of the sick and injured; procurement, storage, and custody of medical department property; preparation of required medical reports; and maintenance of Health Records.

9-17. Limitations

(1) The Medical Department representative shall not attempt to perform medical or surgical procedures for which he or she is not professionally qualified.

(2) If it becomes necessary to perform limited physical examinations, sign original entries in the Health Records, and undertake other professional and administrative duties normally performed by medical officers, Hospital Corps personnel shall perform these duties only when a medical officer is not available and with the approval of their commanding officer.

9-18. Organization

(1) On ships without a medical officer assigned, the formation of a medical department organization shall be at the discretion of the commanding officer in accordance with fleet and type command regulations and instructions. If a separate medical department organization is not appropriate, the Medical Department representative and subordinate Hospital Corps personnel or strikers shall be assigned, for military and administrative purposes only, to another department. This assignment shall not conflict with medical responsibilities. (See art. 9-8.)

(2) For professional medical matters the Medical Department representative reports directly to the commanding officer who retains authority and final responsibility to establish medical policies, act on medical matters or recommendations, and approve transfer of personnel for medical reasons.

(3) A detailed medical organization manual shall be required in ships in accordance with fleet and type commander regulations and instructions. Also those publications required by BUMEDINST 6820.4 series and other applicable COMNAVMECOM and type commander directives shall be maintained on file in the sickbay for ready reference.

9-19. Utilization

(1) Medical Department personnel shall not be assigned to any duty not directly related to patient care, or to the administration of medical units or medical facilities thereof (NAVREGS 0845).

9-20. Assumption of Duties

(1) Within 30 working days after reporting aboard for duty, the Medical Department representative shall conduct a material and administrative inspection of all medical spaces, records, supplies, and equipment. Particular attention shall be given to the class of drugs. (See chap. 21 of this Manual.)

(2) A letter report, citing all deficiencies found, shall be made to the commanding officer. Depending on the type and number of deficiencies noted,

the commanding officer shall take such action as deemed appropriate.

9-21. Drills and Emergencies

(1) The assignment of the Medical Department representative to standard ship's bills shall be in accordance with the Naval Warfare Pamphlet 50 series publication or as directed by the commanding officer.

(2) The Medical Department representative shall be prepared to render emergency medical care at all times. The MDR shall ensure the proper distribution of medical supplies and equipment to the battle dressing stations, decontamination stations, repair parties, and to all spaces manned during general quarters. The MDR shall arrange in advance for assignment of space to care for the overflow of personnel casualties. The MDR shall ensure that all stretcher bearers are instructed in the proper methods and routes to be used in transporting casualties to treatment stations. A place shall be assigned for collection of the dead.

(3) Specific guidelines for emergency preparedness will be provided by fleet and type command regulations and instructions.

9-22. Duties

(1) The Medical Department representative shall perform the following primary duties, in addition to

those that may be assigned to accomplish the specific mission of the command:

(a) Conduct a routine daily sick call and advise the commanding officer of the status of the sick and injured of the command.

(b) Exercise supervision over subordinate Hospital Corps personnel and the medical spaces of the command.

(c) Take charge of all medical supplies and equipment; ensuring the proper receipt, expenditure, accounting, and stowage of that material.

(d) Coordinate a vigorous preventive medicine program in accordance with the standards of chapter 22 of this Manual and NAVMED P-5010-5, Manual of Naval Preventive Medicine.

(e) Recommend to the commanding officer, and effect, a schedule of instruction in first-aid and self-aid for all hands. The use of training aids, training films, and practice material is highly recommended.

(f) Cooperate and participate in matters concerning the safety of the crew and habitability of living spaces.

(g) Forward appropriate clinical samples to the nearest supporting laboratory, in accordance with BUMEDINST 6200.1 series, in event of a suspected biological warfare attack.

(2) The Medical Department representative shall be guided by and make reference to instructions, regulations, and manuals promulgated by COMNAVMEDCOM, systems commands, fleet and type commanders, and the command to which attached.



Chapter 10

CIVILIANS

Sections

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Section I. CIVILIAN EMPLOYEES

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10-1. General

(1) This section contains general instructions pertaining to civilian personnel management at Navy Medical Department activities. More specific and detailed civilian personnel policies, regulations, and procedures are issued by the Office of Personnel Management (OPM) and the Department of the Navy's Office of Civilian Personnel Management (OCPM) and are codified in the Federal Personnel Manual (FPM) and Civilian Personnel Instructions (CPIs), respectively. In addition, NAVMEDCOM directives may be issued to advise commands of special Command policies and of civilian human resource management matters peculiar to Navy Medical Department activities.

(2) Navy Civilian Manpower Management Instruction (CMMI) 250 sets forth the Navy's policy, organization, and assignment of program responsibility for civilian human resource management. The Navy's philosophy is that the purpose of civilian human resource management is to aid managers in mission accomplishment and that basic responsibility for civilian human resource management, whether at the Headquarters or a field activity, rests with the commanding officer. Accordingly, not only the COMNAVMEDCOM, but also commanders, commanding officers and officers in charge of field activities have been delegated authority to classify civilian positions through grade GS/GM-15 and to effect

appointments and other personnel actions (see CMMI 311). Commanders and commanding officers, however, are required to have available the services of a civilian personnel office organized and operated in conformance with CMMI 250. Activities of sufficient size to support a staff of well-qualified civilian personnel specialists and technicians may have their own civilian personnel office. Smaller activities, depending on size, location, and special circumstances, are encouraged to obtain all or partial civilian personnel administration services from another activity or from a consolidated civilian personnel office. Regardless of whether civilian human resource management services are obtained in-house or from another source, the civilian personnel officer will serve as the commander or commanding officer's principal advisor, and act as his or her representative in the administration of the civilian human resource program. CMMI 250 further stipulates that the commander or commanding officer and civilian personnel officer shall have ready and effective access to each other, and that the civilian personnel officer shall report directly to the commander or commanding officer or the executive officer.

10-2. NAVMEDCOM Policy

(1) NAVMEDCOM subscribes completely to the concept that civilian human resource

management and the responsibility for the administration of personnel policies and programs is inherent in command responsibility. Accordingly, commanders, commanding officers, and officers in charge of field activities of the Navy Medical Department will be expected to exercise their delegated authority to classify civilian positions and effect civilian personnel actions except where specifically limited by NAVMEDCOM directives.

(2) Navy Medical Department activities employing civilians shall make provisions for adequate staff services in the civilian human resource management area. Irrespective of whether personnel management services are obtained in-house or from another source, the organizational location and reporting lines of the civilian personnel office will be in compliance with the provisions of CMMI 250.

10-3. Organizational Relationships

(1) Commands will normally look to their in-house civilian personnel officer or to their servicing civilian personnel office for advice and assistance on civilian human resource management matters. However, if additional counsel or assistance is needed, commands should feel free to consult NAVMEDCOMS Director, Civilian Personnel Division (MEDCOM-52), who is the command's liaison with the Office of Civilian Personnel Management (OCPM). Moreover, commands are free to contact directly technical codes OCPM regional offices. However, if such direct contacts involve policy matters, controversial circumstances, or items of significant public or Congressional interest, commands should inform MEDCOM-52.

Section II. CIVILIAN POSITIONS

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10-4. Funds

(1) Funds for personal services are provided in the annual operating budget issued to each activity for appropriate expenses. Subject to the availability of resources, and the limitations contained in article 10-5, commands may establish or abolish positions which best fit the mission and needs of the activity.

10-5. Establishment of Positions

(1) All civilian positions must be established in accordance with applicable laws and regulations.

(2) The numbers of available high grade positions are subject to strict limitations imposed by higher authority and any action to upgrade an existing GS/GM-12, -13, or -14 shall be submitted to MEDCOM-52 for pre-audit. Under no circumstances is final certification action to be taken by the servicing classifier prior to the pre-audit. These actions must be accompanied by the predecessor position description, comprehensive evaluation statement; audit notes containing specifics for the upgrade; statement regarding any position replaced or affected; organization chart for the organizational segment showing other civilian positions by title, series, and grade military supervisory billets; and functional statement.

Section III. CIVILIAN PHYSICIANS

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10-6. General

(1) The absence or nonavailability of a Medical Corps officer, or the nonavailability of a Medical Corps officer with a particular qualification, may at times necessitate the employment of a civilian physician.

(2) Positions for civilian physicians shall be established in accordance with articles 10-5 and 10-8.

(3) Civilian physicians may be used on a full or part-time basis at NAVMEDCOM activities within contiguous U.S. and at certain overseas activities to augment the military medical staff.

(4) Civilian physicians may also be used on a full or part-time basis at industrial and industrial-type activities of the Navy and Marine Corps. At certain locations, it may be necessary to use the services of civilian physicians in the absence of a Navy medical officer.

(5) This section in no way alters provisions of chapter 11, section II; SECNAVINST 6320.8 series; NAVMEDCOMINST 6320.1 and 6320.3 series.

10-7. Methods of Obtaining Services

(1) Civil Service Appointments as Physicians.—Activities shall employ civilian physicians pursuant to the Office of Personnel Management rules and regulations plus applicable civilian personnel instructions issued by the Department of the Navy which cover the subjects of position classification, appointment, compensation, and all other aspects of regular Federal employment. If there are no acceptable candidates for such employment, activities may consider the procurement of needed medical services through the use of experts, consultants, and contracts.

(2) Contracts for Health Care Services. Contracts for health care services may be considered when there are no acceptable applicants for regular civil service

appointment or in other situations where such appointments would be impractical. All contracts for health care services, except personal services and consultant contracts, must meet the requirements of the Commercial and Industrial-Type Activities (CITA) Program as established by OMB Circular A-76, implemented by DOD Directive 4100.15 and DOD Instruction 4100.33 for the Department of Defense, and further implemented by OPNAVNOTE 4860 of 12 September 1980 for the Department of the Navy. Requests to contract out health care services under the CITA program shall be forwarded to NAVMEDCOM for further clearance and announcement and final approval by higher authority prior to any procurement action such as bid solicitation. Personal services contracts are governed by FPM 304 and CPI 304. See CPI-304.1 for use in the departmental service.

(3) Employment as Experts or Consultants.—Employment of civilian physicians as experts or consultants is governed by FPM/CPI Chapter 304. Special procedures are required for employment in the departmental service, see CPI-304.1.

10-8. Selection

(1) Careful selection of civilian physicians is essential to ensure the highest standards of professional service. The qualification requirements for physicians appointed under article 10-7(1) will be in accordance with the qualification standards for medical officers established by the Office of Personnel Management in Handbook X-118. Direct hire authority has been authorized by the Office of Personnel Management. Authority letters may be obtained from MEDCOM-52. For a non-U.S. citizen physician in a foreign area, the qualification standards that apply locally will be used. A physician whose services are to be obtained through appointment as an expert or consultant or by a contract for medical services must be a certified member of an American Specialty Board, or the

equivalent, and must be recognized as a practitioner of excellent qualifications with a high degree of attainment in the physician's professional field. The qualification standards for medical officers established by the Office of Personnel Management shall be used as a guide for qualification requirements for physicians providing services procured under article 10-7(2).

(2) Civilian physicians selected must (a) be graduates of an accredited medical school; (b) be currently licensed to practice in a State or Territory of the United States; (c) possess high moral, professional, and ethical standards; and (d) be in good professional standing in their respective communities.

(3) If the civilian is a non-U.S. citizen, the requirement that the civilian be currently licensed to practice in a State or Territory of the United States is waived, providing the civilian performs Navy duties in a foreign area.

10-9. Security Clearances

(1) Security investigations for physicians who are employed or furnish professional medical services under the provisions of this section shall meet the requirements of the Civilian Manpower Management Instructions and the Department

of the Navy Security Manual for Classified Information (OPNAVINST 5510.1 series).

10-10. Duties

(1) Civilian physicians may be used to perform any professional duties for which they are qualified.

(2) Under the direction of a Navy Medical Corps officer, they may perform general medical duties involving military personnel with the exception of those purely military in nature such as:

(a) Physical examination of candidates for duty involving flying, submarine service, and diving, or other examinations that must be performed by specially qualified medical officers.

(b) Physical examinations for promotion of active duty officers or examinations of applicants for appointment to commissioned status in the Regular Navy or Marine Corps.

(c) Physical examinations of applicants to officer candidate training programs.

(d) Physical examinations of officers of Reserve components incident to reporting for active duty other than for training.

(e) Exercise of military command and administration over naval uniformed personnel.

(f) Duties as a member of medical boards or physical evaluation boards.

Chapter 12

EDUCATION AND TRAINING

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12-1. Background

(1) The authority and responsibility for the professional education and training of Medical Department military personnel are vested in the Bureau of Medicine and Surgery by BUPERSMAN 6620100.

(2) The fundamental policy of the Bureau of Medicine and Surgery is to encourage and support education and training activities directed toward the acquisition, maintenance, and improvement of the qualifications and skill levels of all Navy Medical Department personnel.

12-2. Responsibilities

(1) By direction of the Chief of Naval Operations, the Naval Health Sciences Education and Training Command was established and charged with the mission to, under the immediate direction of the Chief, Bureau of Medicine and Surgery, implement policy and exercise control, administration, and management of health sciences education and clinical investigation training programs for the Department of the Navy; develop plans, objectives, priorities, organization, procedures, and standards to meet education and training requirements; establish, evaluate, and maintain optimal health sciences educational and training programs that will ensure maximal responsiveness to the operational and professional needs of the service; and provide budgetary support for the training activities and programs of the Medical Department of the Navy.

12-3. Scope

(1) Medical Department education and training programs shall be organized to effectively support Navy, Marine Corps, and Medical Department missions.

(2) Medical Department education and training shall be conducted in support of validated requirements for undergraduate, postgraduate, doctoral, and continuing education and functional training.

12-4. Medical Corps Programs

(1) Indoctrination

(a) All newly appointed Medical Corps officers, except those who have received indoctrination training prior to reporting for active duty, will be ordered to designated medical facilities for basic indoctrination.

(b) The purpose of this course is to provide officers with a basic orientation to the Navy Medical Department, the role of the naval officer, and Navy regulations and administrative practices.

(2) Graduate Medical Education

(a) The Navy offers 33 inservice training programs in eight teaching medical centers. Four are multispecialty and four are family practice training hospitals:

Multispecialty
NNMC, Bethesda, MD
NRMCC, Oakland, CA
NRMCC, Portsmouth, VA
NRMCC, San Diego, CA

Family Practice

NRMC, Charleston, SC
 NRMC, Camp Pendleton, CA
 NRMC, Jacksonville, FL
 NARMC, Pensacola, FL

(b) A limited number of full-time outservice training positions in civilian institutions are sponsored by the Navy for those specialties and subspecialties for which no Navy or other military conducted program is available and for which there is a clearly defined Navy Medical Department requirement.

(c) All applications for training are to be submitted in accordance with the current BUMED INST 1520.10 series, as outlined in the current BUMED Notice 1520. Applications are reviewed annually at the Surgeon General's Specialties Advisory Conference. Each specialty committee makes recommendations for selection concerning its appropriate specialty to the Chief, Bureau of Medicine and Surgery, who has final approval authority.

*(3) Special Operational Training.—**(a) Aerospace/Undersea Medicine.—*

(1) Aerospace medicine training is conducted at the Naval Aerospace Medical Institute in Pensacola, FL. Three classes are convened each year. Flight surgeon training is a 6-month course in which the first phase provides training and experience in special problem areas created by the environmental stress placed on aviators. The second phase consists of 6 weeks of ground school and basic flight training, up to and including solo flight.

(2) Courses of instruction for undersea medical officers, of approximately 6 months duration, are convened twice yearly at the Naval Undersea Medical Institute, Naval Submarine Medical Center, Groton, CT. The curriculum includes diving, submarine, and nuclear medicine.

(3) Unless the needs of the service otherwise dictate, the graduates in aerospace medicine or undersea medicine will serve in an operational duty assignment for a period of 2 years following completion of the course.

(4) All applications are to be submitted in accordance with the current BUMEDINST 1520.10 series as outlined in the current BUMED Notice 1520.

(b) Gorgas Course: "Medicine in the Tropics".—

(1) In support of contingency training, the Navy sponsors a 6-week course, "Medicine in the Tropics," at the Gorgas Memorial Laboratory in Panama. This course provides an excellent opportunity for selected medical officers to gain first-hand exposure to the management of infectious diseases and related illnesses which are associated with operations in tropical and subtropical areas of the world. This course convenes four times per year.

(2) Nominations are solicited from residency programs at the Navy's eight teaching hospitals.

(3) All nominations are submitted to the Naval Health Sciences Education and Training Command and forwarded to the course director for final selection of course attendees.

(4) Continuing Medical Education.—

(a) With the rapid changes in the technology, administration, and delivery of health care, continuing medical education (CME) is important for the maintenance of professional competence and performance.

(b) Attendance at short courses, workshops, seminars, symposia, and professional meetings is a valuable means for Medical corps officers to achieve professional growth and acquire new knowledge and skills.

(c) All Medical Corps officers are encouraged to participate in appropriate professional health related continuing education experiences. To the extent that available appropriate funds will permit, it is desirable that all Medical Corps officers on active duty be authorized to attend at least one continuing education experience or professional conference per year on a temporary additional duty basis. Those medical officers outside the contiguous United States are not usually funded for annual continuing medical education endeavors. All requests for funding should be submitted in accordance with the current BUMED INST 4651.1 series. Bureau of Medicine and Surgery funded activities have the responsibility to program and budget funds to support these endeavors.

(d) The Naval Health Sciences Education and Training Command has approval from the American Medical Association to review naval continuing medical education programs for Category I AMA credit. All requests for accreditation should follow the criteria outlined in the AMA Physician's Recognition Award Handbook.

(5) Medical Corps Professional Certification Examinations.—

(a) To promote and ensure quality medical care in the Navy, and contingent upon the availability of appropriated funds, qualified Medical Corps officers will be sponsored for participation in appropriate professional examinations for board certification which may be required by the Bureau of Medicine and Surgery to meet the needs of the Medical Department. Those examinations considered to be a basic requirement for commissioning in the Medical Corps will not normally be funded, i.e., National Boards, FLEX, and State licensure.

(b) All requests for funding should be submitted in accordance with the current BUMEDINST 1500.4 series.

(c) Recertification examinations will normally be funded only for career officers whose specialties require recertification. Those physicians who desire to voluntarily recertify may request funding of these efforts in lieu of their annual continuing medical education experiences.

Recertification will entail a non-cumulative, one-year service obligation.

(6) *Clinical Investigation Program.*—

(a) Clinical investigation, as outlined in the current BUMEDINST 6000.4 series, is an essential component of optimum medical care and medical education in the Navy, which embraces the organized inquiry into clinical health care problems. The clinical investigation program is organized to meet the following objectives:

(1) To achieve continuous improvement in the quality of patient care.

(2) To provide experience in the mental discipline of clinical investigation.

(3) To maintain an atmosphere of inquiry consistent with the dynamic nature of the health sciences.

(4) To maintain the high professional standing and accreditation of advanced health education programs.

(b) Currently, there are four major clinical investigation centers: the National Naval Medical Center, Bethesda, and the Naval Regional Medical Centers, Portsmouth, San Diego, and Oakland. Each unit is under the direction of a Chief, Clinical Investigation Center, who is responsible to the commanding officer of the respective medical center. All clinical investigation protocols must be submitted to the Naval Health Sciences Education and Training command via a clinical investigation center in accordance with the current BUMEDINST 6000.4 series.

(7) *Physician's Assistant Programs.*—

(a) *Continuing Education.*—Warrant officer physician's assistants are encouraged to participate in appropriate professional health related continuing education experiences. Requests for funding should be submitted in accordance with the current BUMED INST 4651.1 series. Bureau of Medicine and Surgery funded activities have the responsibility to program and budget funds in support of these endeavors.

(b) *Licensure and Certification.*—After the completion of their phase II clinical internship and contingent upon the availability of appropriated funds, qualified warrant officer physician's assistants will be sponsored for participation in their physician's assistant certification examination.

(c) *Part-Time Outservice Training.*—Warrant officer physician's assistants may apply for financial assistance in accordance with the current BUMED INST 1500.7 series for courses related to their professional development.

12-5. Dental Corps Programs

(1) See Chapter 6, Dental Corps, Section XVI, Dental Officer Training.

12-6. Medical Service Corps Programs

(1) *Basic.*—

(a) The qualification standards for appointment in the Medical Service Corps establish a presumption that each appointee is qualified to embark on a career in the Corps and to perform the general duties required of a junior officer.

(b) Either before or immediately subsequent to commissioning, Medical Service Corps officers should undergo basic orientation and indoctrination. The objective of this training is to orient them in naval customs, traditions, and regulations, and to develop skills in naval leadership, administration, and related subjects.

(2) *Operational.*—

(a) Upon completion of the basic indoctrination course and assignment to a field or headquarters activity, continued instruction of Medical Service Corps officers becomes a command responsibility. Within each command, a senior Medical Service Corps officer will be designated to establish, coordinate, and maintain an organized training program for Medical Service Corps officers. That officer will instruct junior officers in their duties and responsibilities and will familiarize them with the mission, responsibility, and scope of the command. Organized instruction on pertinent military and Medical Department subjects is vital to the success of the program. The broadening of mental outlook and resultant increase in professional knowledge will enable the officers to better fulfill the requirements and responsibilities of higher grade.

(b) Experience acquired through an officer's dedicated performance of duty, coupled with progressive assignments involving greater responsibilities, is most significant to professional development. Concurrently, participation in part-time academic courses taken either by correspondence or in person during off-duty hours is encouraged. Courses offered by civilian educational institutions, when of service benefit, can in part be underwritten financially under the terms of current Naval Military Personnel Command and Bureau of Medicine and Surgery instructions. Further, attendance at professional and scientific meetings, which are held in most locales, provides an effective means whereby an officer may keep abreast of advancements in personal specialty, and is strongly encouraged.

(c) Each officer has a major share in career management and planning. The primary responsibility concerning military character and professional competence similarly lies with the individual officer.

(3) *Full-Time Training.*—

(a) A formal training program for Medical Service Corps officers, encompassing full-time academic training in service and civilian

institutions, is administered by the Bureau. The general objectives are:

(1) To provide for the manning of every billet by an officer of appropriate qualifications in order that the maximum effectiveness of each position may be achieved.

(2) To satisfy the normal desire for self-improvement.

(3) To advance the Navy's contribution to the fields in which Medical Service Corps officers serve.

(b) The following are general points of philosophy guiding the administration of the Medical Service Corps full-time training program:

(1) Each training assignment will be governed by a validated requirement and must result in demonstrable benefit to the service.

(2) In each training assignment, the qualifications of the individual to pursue the training and to apply its fruits must be optimum.

(3) Each training assignment must be consistent with the individual's career pattern.

(4) Such resources as are available may be devoted to the training program, but not to the detriment of the continuing fulfillment of the corps' responsibilities in operational billets.

(5) In order that maximum service benefit may be assured, the choice of institutions in which training is to be accomplished and decisions concerning curriculum content are the functions of the Bureau of Medicine and Surgery; due regard is to be given to the wishes of the individual concerned.

(c) The current curricula available, eligibility requirements, and application procedures are set forth in the current BUMEDINST 1520.12 series.

(4) *Continuing Education.*—A variety of continuing education opportunities are available to Medical Service Corps officers of the Regular Navy and reserve officers on extended active duty. To the extent that available appropriated funds will permit, it is desirable that all Medical Service Corps officers on active duty be authorized to attend at least one continuing education short course or conference per year on a temporary additional duty basis. Bureau of Medicine and Surgery funded activities have the responsibility to program and budget funds to support these endeavors. All requests for external funding should be submitted in accordance with the current BUMEDINST 4651.1 series.

(5) *Licensure and Certification.*—Qualified Medical Service Corps officers will be sponsored for participation in appropriate professional examinations for licensure or certification which may be required by the Bureau of Medicine and Surgery to meet the needs of the Medical Department. Those examinations considered to be a basic requirement for commissioning in the Medical Service Corps will not normally be funded. All requests for funding

should be submitted in accordance with the current BUMEDINST 1500.4 series.

(6) *Part-Time Outservice Training.*—Medical Service Corps officers may apply for financial assistance for courses which are an integral part of an accredited program leading to a degree in the professional fields associated with the Medical Service Corps or which would enhance the officer's general capacity to contribute to the naval service. All requests for funding should be submitted in accordance with the current BUMEDINST 1500.7 series.

12-7. Nurse Corps Programs

(1) *Indoctrination.*—

(a) All newly appointed officers of the Nurse Corps should attend the Officer Indoctrination School, Naval Education and Training Center, Newport, RI, prior to reporting to their first duty station.

(b) The purpose of this course is to provide officers with a basic orientation to the naval establishment, the Medical Department, the role of the naval officer, and the development of skills in naval leadership and administration.

(2) *Full-Time Duty Under Instruction.*—

(a) Opportunity to enroll in undergraduate, graduate, and specialty programs on a full-time basis is offered to Nurse Corps officers in accordance with the current BUMEDINST 1520.14 series to satisfy the following objectives:

(1) To fulfill validated requirements of the Nurse Corps.

(2) To ensure an inventory of officers with the technical, scientific, and managerial knowledge necessary to permit effective assignments.

(3) To provide a mechanism for members of the Nurse Corps to continue their professional development through formal academic study.

(b) Officers assigned to full-time duty under instruction must:

(1) Request a course of study in accordance with BUMEDINST 1520.14 series which satisfies an identified requirement.

(2) Be academically qualified, have outstanding performance records, and demonstrate an aptitude for the requested program of study.

(3) Agree to fulfill an active duty commitment based on the length and type of academic program pursued.

(4) Be selected by a professional advisory board convened by the Chief, Bureau of Medicine and Surgery.

(c) The Bureau of Medicine and Surgery retains the right to restrict enrollment to those institutions wherein the maximum benefit from available resources may be realized.

(3) *Continuing Education.*—Since completion of a basic program of study in nursing fulfills only the

minimum requirements for professional practice, the Medical department supports and encourages continuing education for Nurse Corps officers. While the responsibility for continuing one's education remains that of the individual officer, the following resources are available:

(a) *Part-Time Outservice Courses*.—Officers may apply for financial assistance in accordance with the current BUMEDINST 1500.7 series for courses which are an integral part of an accredited program leading to certification, or an undergraduate or graduate degree in a field pertinent to present or future responsibilities as a Nurse Corps officer.

(b) *Short Courses*.—A program of short courses is conducted by Navy Medical Department activities to provide Nurse Corps officers with educational opportunities beyond their basic professional preparation. In addition, attendance at short courses, institutes, seminars, workshops, conferences, and conventions conducted by other Federal services, universities, professional organizations, and civilian agencies is encouraged. Officers may apply for authorization or funded orders from their local commands or the Naval Health Sciences Education and Training Command in accordance with the current BUMEDINST 4651.1 series.

(c) *Continuing Education Approval and Recognition Program (CEARP)*.—The Naval Health Sciences Education and Training Command is accredited by the American Nurses' Association as a provider and approver of continuing education for nurses. This is intended to provide:

(1) A mechanism whereby courses developed by Navy Medical Department activities and independent study can be evaluated and approved for continuing education credit.

(2) Maximum transferability and recognition of continuing education credits earned by Nurse Corps officers.

(d) *Inservice Education*.—Ongoing inservice education programs are conducted by local commands for all nursing service personnel to validate competence, to provide competency training, and to update knowledge of techniques, procedures, and policies. The needs identified by the staff or the institution will determine the courses included in these programs.

12-8. Medical Department Enlisted Programs

(1) *General*.—The Chief, Bureau of Medicine and Surgery is responsible for all training of Medical Department enlisted personnel except general military training which is under the cognizance of the Chief of Naval Education and Training. Training quotas are established annually and reviewed quarterly to ensure that billet revisions authorized by the Chief of Naval Operations are properly reflected in

the training plan. Training quotas represent the number of students required to staff authorized billets at 100 percent and, ideally, should negate the need for on-the-job training in those specialties for which formal training is available. On-the-job training of technicians in specialties for which a formal program exists reduces the number of general service personnel available to meet other authorized requirements; hence, it is authorized only as outlined in the BUMEDINST 1510.10 series. Training consists of class "A" basic schools, formal training programs for technicians taught in class "C" schools, inservice training, part-time outservice training, and continuing education/professional update training.

(2) *Class "A" Basic Schools*.—The mission of class "A" basic schools is to instruct and train Medical Department enlisted personnel in basic subjects and procedures necessary to qualify them for general duties normally required of enlisted personnel during their first enlistment in the naval service. Class "A" school is mandatory for all such personnel first reporting to active duty if comparable training has not previously been completed. This school, together with the subsequent inservice training which they will receive, is designed to prepare all Medical Department enlisted personnel for advancement in rate through third class petty officer. Upon completion of a class "A" school appropriate entries shall be made in the individual's service record and a training certificate issued.

(3) *Formal Inservice Training, Class "C" Schools*.—Formal training courses for Medical Department enlisted personnel are listed in the NAVEDTRA 10500, Catalog of Navy Training Courses (CANTRAC), which provides data on the purpose, scope, prerequisites, location, and convening dates of the courses. Requests for training should be submitted to the Commander, Naval Military Personnel Command via the Chief, Bureau of Medicine and Surgery (MED 25 for Hospital Corps personnel and MED 41 for dental technicians) using form NAV PERS 1306/7. Selection of candidates for training is a competitive process which includes a comprehensive review of each candidate's potential. Candidates should consider the career pathways for Medical Department personnel when applying for training (BUMEDINST 1510.10 series). Personnel volunteering for duty with the Fleet Marine Force may do so by requesting assignment to a field medical service school. Personnel earning an NEC as a result of formal training will be designated in the Naval Manpower Information System automatically through the Navy Integrated Training Resources and Administration System or by the Bureau of Medicine and Surgery, if indicated, in accordance with NAV PERS 18068D, Section II, Manual of Navy Enlisted Manpower and Personnel Classifications and Occupational Standards. If selected for class "C"

training, candidates are usually ordered to duty under instruction at the time of sea or shore rotation. Upon successful completion of technical training a Certificate of Special Instruction will be issued and appropriate entries made in the service record.

(4) *Inservice Training.*—The inservice training program, including lesson plans and on-the-job training guides, shall be developed utilizing the occupational requirements established in NAVPERS 18068D, Section I, Navy Enlisted Occupational Standards for each pay grade in Occupational Field 14, Health Care. The inservice training program for each rate should be developed locally and monitored by the education and training officer to determine that instruction, both formal and on-the-job, is being assimilated by the trainee. Periodic examinations should be administered and the results incorporated into recommendations for advancement. Commanding officers shall designate an officer of the Medical Department, or the Medical Department representative, as the education and training officer for this program. That individual shall be directly responsible to the commanding officer for the development, organization, administration, and direct supervision of the inservice program, and shall consult with the commanding officer on a regular basis concerning the status, success, and requirements of the program. An officer of the Nurse Corps, if available, should be appointed to assist the education and training officer in the development, implementation, and supervision of all phases of the inservice training program devoted to nursing subjects. BUMEDINST 1510.8 series provides a guideline for development and implementation of the inservice program.

(5) *Part-Time Outservice Training.*—The Bureau of Medicine and Surgery encourages Medical Department personnel to take advantage of part-time outservice training in accredited civilian institutions and will authorize tuition aid, provided funds are available, for courses directly related to areas of Medical Department responsibility. Such areas are considered to be physical, chemical, clinical, biological, and socio-psychological sciences and the fields of Medical Department administration. Consideration will also be given to requests for other courses if they are a necessary part (required credits or prerequisites to desired courses) of a fully planned program leading to a degree or certificate which will enable the applicant to assume increased responsibility or to function more effectively. Accredited institutions of higher education are those listed in the latest U.S. Office of Education's Educational Directory, Part III, Higher Education. Certain high school and college courses may be considered as accredited at the discretion of the Naval Health Sciences Education and Training Command, Bethesda, MD. To be eligible to participate, personnel must be members of the Medical Department on active duty, either in the Regular Navy or the Naval Reserve. Medical Department

enlisted personnel must have 1 year of obligated service remaining following completion of the most recent course for which funding was received. Information concerning requirements and administrative procedures for the part-time outservice training program are contained in BUMEDINST 1500.7 series.

(6) *Continuing Education and Professional Update Training.*—Medical Department personnel may be sponsored by their local command or, to the extent funding is available, the Naval Health Sciences Education and Training Command, to attend health related continuing education activities, conferences, and professional meetings. BUMEDINST 4651.1 series provides guidance for application and funding procedures.

12-9. Armed Forces Health Professions Scholarship Program

(1) *Authority and Purpose.*—The Armed Forces Health Professions Scholarship Program (AFHPSP) was established through the enactment of the Uniformed Services Health Professions Revitalization Act of 1972 (Public Law 92-426) for the purpose of obtaining adequate numbers of commissioned officers on active duty who are qualified in the various health professions.

(2) *Scope.*—The AFHPSP provides a participant with the following financial support:

(a) Full payment of tuition and required fees.
(b) Full reimbursement of expenses incurred in the purchase of required textbooks and equipment items.

(c) Payment of a monthly stipend for 10.5 months per year.

(d) Forty five days annual active duty for training in pay grade O-1 during each year of program participation.

(3) *Service Requirement.*—

(a) The obligated service required for participation in the AFHPSP shall be as directed in DOD Directive 1215.14 (enclosed in SECNAVINST 1520.8 series). It shall, however, never be less than a minimum of 1 year of active service for each year of financial support.

(b) SECNAVINST 1520.8 series provides policy on release from the service requirement and procedures for entrance onto active duty.

(4) *Eligibility Requirement.*—

(a) A candidate must be enrolled in or accepted into an approved school of the health profession concerned, in the United States or Puerto Rico.

(b) A candidate must be a citizen of the United States.

(c) A candidate must meet the requirements of appointment as a commissioned officer.

(d) A candidate must meet the age requirements set forth in BUPERSMAN 1020100. In

particularly worthy cases, waiver may be granted by the Commander, Naval Military Personnel Command.

(5) *Responsibilities.*—

(a) DOD Directive 1215.14 places the responsibility for the implementation of the Navy's portion of the AFHPSP upon the Secretary of the Navy.

(b) SECNAVINST 1520.8 series implements DOD Directive 1215.14 and places the responsibility for the administration and management of the AFHPSP (Navy) with the Chief, Bureau of Medicine and Surgery.

(c) BUMEDINST 1520.21 series directs the Commanding Officer, Naval Health Sciences Education and Training Command to assume responsibility for the preparation of budget and accounting data applicable to the AFHPSP; to assume command responsibility for student officers while in an inactive duty status and to issue annual active duty for training orders; and to review and approve claims for reimbursement submitted by students and invoices submitted by accredited civilian institutions for payment of required tuition and fees for students in the program.

12-10. Operational Medicine Programs

(1) The Operational Medicine Department of the Naval Health Sciences Education and Training Com-

mand acts as the central focus for coordinating the implementation of operational medicine training programs for officers and enlisted personnel of the Medical Department. HSETC is charged with identifying requirements in operational medicine to include both primary and continuing education and training.

(2) A number of programs are designed to provide personnel who are anticipating operational tours of duty with the knowledge and skills necessary to perform effectively in the fleet and field environment. Other programs are developed to provide updated information and to facilitate the learning of new skills for personnel currently assigned to tours of duty in the operational arena. The majority of education and training programs are evolved to incorporate actual practical experience requirements.

(3) All education and training programs are continuously evaluated and modified by consultants in various fields of operational medicine training. Consequently, programs are tailored to meet the specifically identified needs of the operational environment and to meet the requirement for providing medical training that is in accordance with advances in military training and the overall mission of combat readiness.

(4) Specific course availability is promulgated by means of official directives.

Chapter 14

SPECIAL ACTIVITIES

Sections

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Section I. TRANSPLANTATION SUPPORT

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14-1. Location

(1) Transplantation support is available as a by-product of the Navy Transplantation Research Program performed by the Naval Medical Research Institute, National Naval Medical Center, Bethesda, Maryland 20014.

14-2. Mission

(1) The mission of the Navy Transplantation Research Program is to conduct basic and applied research in the broad area of transplantation immunology and to make available to the medical community such knowledge, products, and services which result. The mission includes support for training of NEC HM-8433 Transplantation Technicians.

14-3. Tissue Banking Support

(1) *Collaborator Agreement.*—Human allograft material is provided as necessary to support research protocols. Material is provided only to collaborators who have agreed in writing to cooperate in research efforts and provide clinical data on graft recipients.

(2) *Participation in the Tissue Graft Registry.*—All human allografts provided to collaborators will be recorded in the Tissue Graft Registry. Complete followup information will be secured on each recipient. These data are designed to provide clinical information for application in the care of casualties.

(3) *Tissues Involved in Allograft Application.*—

(a) *Bone.*—Bone graft may be used fresh, frozen, or freeze-dried. Investigations indicate that graft preserved by freeze-drying is associated with little or no immune response in the host. Preserved bone grafting has widespread application, the results of which are very encouraging. Packing of bone cysts, spine fusions, grafting of fractures, and segmental grafts in long bones are common applications for banked bone graft. Periodontal defects have been successfully treated with ground cortical bone. In other applications, the results are variable.

(b) *Skin.*—Stored skin grafts used in severely burned patients (30 percent full thickness or greater) may significantly reduce morbidity and mortality, particularly when used as a dressing. Allograft skin has been shown to be valuable in the treatment of other acute and chronic skin lesions where control of infection and the preparation of a granulation bed is necessary.

(c) *Dura*.—Results indicate that freeze-dried dura, when used to replace large dural defects, constitutes a valuable addition to the neurosurgeon's armamentarium.

(d) *Fascia*.—Freeze-dried fascia grafts yield clinically favorable results when used in repair of hernia, facial paralysis, radical breast resections, Lowman-type procedures, and filling soft tissue defects.

(e) *Cornea*.—Fresh corneal tissue is made available in the immediate area of the National Naval Medical Center. Frozen viable cornea is being evaluated and will be available for collaborative studies.

(f) *Bone Marrow*.—Allogenic histocompatible bone marrow transplantation is generally recognized as the treatment of choice for severe aplastic anemia, idiopathic or due to radiation or toxic agents. It is being increasingly utilized in patients with acute leukemia and other malignancies. In addition, cryopreserved autologous marrow transfusions have been successfully used to speed hematologic recovery in

patients undergoing high dose cytotoxic chemotherapy or radiotherapy.

(g) *Kidneys*.—Fresh cadaveric kidneys are used for the treatment of end-stage renal disease. Renal transplantation is available through the agreement between the Naval Medical Research Institute, National Naval Medical Center, and the Walter Reed Army Medical Center establishing the Army-Navy Transplant Service in 1977.

(h) *Vascular*.—Lyophilized veins are used for mesocaval shunt, vascular access for hemodialysis, and patches and segment grafts for the repair of traumatic vascular injuries.

(i) *Cartilage*.—Costal cartilage is currently being used for reconstructive facial surgery.

(j) *Blood Components*.—Cryopreserved blood components are available for individual clinical and experimental protocol.

(4) *Available Grafts*.—The following grafts are usually available but supplies vary with the availability of donors.

Tissue	Preservation Method	Approximate Size or Unit
Bone:		
Long bone	Frozen	Whole, 1/2 and shaft
Ribs	Freeze-dried	Whole, 1/2 and matchstick
Ilium	Freeze-dried	Whole, strips and chunks
Mandible	Freeze-dried	One
Cortical strips	Freeze-dried	10 x 2 cm
Grounded cancellous	Freeze-dried	1/20 oz, 1 oz, 3 oz
Crushed cortical	Freeze-dried	1/20 oz, 1 oz, 3 oz
Crushed cortical, fine	Freeze-dried	1/20 oz (100-300 μ m particles)
Skin	Freeze-dried	500 sq cm
Dura	Freeze-dried	7 x 8 cm
Fascia	Freeze-dried	11 x 18 cm
Cornea	Fresh	One
Bone marrow	Cryopreserved	
Kidney	Fresh, perfused	One
Vein, saphenous	Freeze-dried	One
Cartilage	Freeze-dried	Chunk
Blood components	Frozen	Specific request

(5) *Other Tissues*.—In addition to the above tissues, the Tissue Bank is constantly evaluating new protocols for the investigation and use of other tissues as grafts. Many of these are currently being studied in animal models prior to release for human use. These include freeze-dried arteries, nerves, tendons, islet cells, and other endocrine tissue.

14-4. Tissue Graft Registry

(1) The Tissue Graft Registry maintained by the Tissue Bank shall include data on graft donors and recipients in accordance with the Privacy Act of 1974. A separate registry is maintained for renal allografts.

(2) Collaborators implanting graft material supplied by the Tissue Bank shall promptly report to the Tissue Bank for entry in the Graft Registry by completing the withdrawal section of the deposit card (Form NDW-NNMC 6143/2A) furnished with the graft. Upon discharge or transfer of the patient from the activity, a copy of the Narrative Summary (Standard Form 502), Operation Report (Standard Form 516), pertinent X-ray films, and the address(es) where correspondence is most likely to reach the patient, shall be forwarded by the patient affairs officer, or one acting in a similar capacity, to the Tissue Bank.

(3) The Tissue Bank shall request, receive, and copy X-ray films pertaining to recipients of bone

tissue allografts and return originals to the originating activity.

(4) The Tissue Bank shall forward to each patient on whom further followup is needed a followup authorization card indicating the dates and nature of studies desired. Arrangements have been made with the Army and Air Force Medical Departments, the Veterans Administration, and the U.S. Public Health Service whereby these requests will be honored by their hospitals. If the facility to which the patient presents cannot perform the requested studies on a nonreimbursable basis, reimbursement is authorized. Standard Form 1080 should be prepared and submitted to the Bureau of Medicine and Surgery, Navy Department, Washington, DC 20372. No funds are currently available for patient travel in connection with this followup study. X-rays, examination reports, and other requested materials should be forwarded to the Tissue Bank. Biopsy or autopsy specimens of the allograft operative site should be forwarded in formalin.

14-5. Tissue and Organ Procurement

(1) For the purpose of obtaining tissue and organs, two teams are available, one for tissue and one for kidneys. In the event of a suitable donor, one or both of these totally equipped procurement teams will be deployed. Tissues and/or kidneys will be removed in the operating room, but in such a fashion as to not interfere with operating room schedules. Both teams are available 24 hours per day for consultation, evaluation, procurement, and preservation of suitable human material.

(2) Tissue donation should be pursued when a person over 12 years old dies within the 48 contiguous United States. Tissue procurement must begin during the first 24 hours after death. Donors are acceptable only in the absence of malignancy, serious infection, and diseases of unknown etiology. A history of tuberculosis, malaria, hepatitis, or malignancy is a contraindication to tissue donation.

(3) Kidney Donors:

(a) Kidney donation should be considered when any person meets the criteria for brain death, but can be maintained with ventilation and cardiovascular support. Donors should be under 55 years of age, free from infection, urinary tract disease, hypertension, diabetes mellitus, collagen disease, malignancy (except central nervous system tumor), sickle

cell disease, evidence of previous or active hepatitis, or positive serology. Renal function must be normal with complete urinalysis and urine culture negative.

(b) When a potential kidney donor is identified, the Army-Navy Transplant Service ((202) 576-3250) or the Tissue Bank (autovon 295-1121) should be notified immediately.

14-6. Immunology and Immunogenetics Support

(1) *Histocompatibility Typing.*—Although HLA typing (A,B,C,D,DR) remains in a developmental status, tissue typing and HLA antibody identification and crossmatching is available on a consultation basis. Training of technicians to perform these assays, as well as reagents and consultation, can be obtained through a collaborative agreement with the Head of the Research Branch.

(2) *Lymphocyte Typing.*—The identification of lymphocyte subsets has become a new tool in the immunodiagnostic field as well as in defining basic concepts of immunoregulation. This area is currently under investigation for the development of new reagents and assays. Current procedures are available on a consultation basis.

(3) *Clinical Immunology.*—Identification of functional defects in the cellular and humoral immune systems requires a battery of assays. Functional immunological monitoring continues to be developed in support of transplantation. These procedures are available through consultation.

14-7. Renal Transplantation

(1) The Naval Medical Research Institute through the Army-Navy Transplant Service is responsible for providing renal transplantation and related procedures to all members eligible for military health benefits.

(2) Patients with malignancy, active infection, or over the age of 65 are excluded from recipient consideration; however, diabetics with end-stage renal failure are candidates for transplantation. Patients with chronic illnesses, such as hepatitis or cardiac failure, require special evaluation.

(3) Patients selected as renal transplant candidates who do not have acceptable living-related donors will be entered into the regional organ sharing computer list for cadaver transplantation. These patients will be maintained on chronic hemodialysis until a suitable kidney becomes available.

Section II. NAVY BLOOD PROGRAM

	Article
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14-8. Mission

(1) The Navy Blood Program manages the collection, production, distribution, use, and disposition of all blood products within the Navy Medical Department.

14-9. Organization

(1) COMNAVMEDCOM.-Commander, Naval Medical Command directs the Navy Blood Program.

(2) The 48 Contiguous United States.-The blood service units in the 48 contiguous United States are organized into four area blood systems. The structure of these area blood systems is based on blood donor availability, blood product demand, and shipping distance factors. As such, the configuration of these area blood systems is unique to the blood program and should not be confused with other medical department regional organizations. One blood service unit within each area blood system is designated as the system directorship. Each directorship acts as the system manager and is a central point of contact for all the blood service units within the directorship's system and COMNAVMEDCOM for blood bank matters.

(3) Other Blood Service Units.-The blood service units outside of the 48 contiguous United States are organized directly under COMNAVMEDCOM.

14-10. Key Functions

(1) COMNAVMEDCOM.-

(a) Serves as executive agent for coordination and management of all Navy blood banking matters.

(b) Serves as Navy representative to or deputy director of the Armed Services Blood Program Office.

(c) Directs the distribution of Navy blood resources and establishes quotas to support local emergencies and mobilization or contingency requirements levied by the Armed Services Blood Program Office.

(d) Collects and maintains data on blood bank operations and takes action, as indicated, for proper allocation of Navy blood resources to ensure their effective and efficient use.

(e) Coordinates the review of all plasma exchange agreements with COMNAVMEDCOM to ensure reciprocity, legality, propriety, and adequacy of exchange rates.

(f) Reviews and takes appropriate action on all contractual agreements for exchange of unexpired blood products.

(g) Serves as control center for all correspondence relative to Navy blood banking matters.

(h) Initiates and maintains directives related to the managerial aspects of the Navy Blood Program.

(i) Performs public information functions for Navy blood banking.

(j) Initiates and coordinates matters relative to special blood projects and studies.

(k) Serves as referral agent and coordinator for technical blood banking matters.

(l) Monitors developments in the preparation and use of blood components and disseminates information, as appropriate.

(m) Coordinates the maintenance of the Navy's license to manufacture blood products under the Department of Health and Human Services, Food and Drug Administration, Office of Biologics licensure program.

(2) Directors, Area Blood Systems.-

(a) Serve as executive agent for coordination and management of all Navy blood banking matters for the assigned area blood system.

(b) Coordinate the area blood system's weekly blood shipments to the Armed Services Whole Blood Processing Laboratory, McGuire AFB, New Jersey, as assigned by COMNAVMEDCOM. Ensure that each active area blood service unit identified in appendix 2, annex E of the NAVMEDCOMINST S4812.1 series, makes a minimum of one shipment containing at least 10 units of whole blood during each quarter. Ensure that all shipments comply with the guidance contained in NAVMED P-5123 and provide immediate notification to COMNAVMEDCOM (MEDCOM-413) if the area blood system is unable to make the full shipment assigned.

(c) Receive blood product inventories from member blood service units and take action to ensure the efficient use of area blood resources.

(d) Make arrangements for shipments of blood products between blood service units within the system area.

(e) Determine quantities of blood products considered excess to area requirements, inform COMNAVMEDCOM (MEDCOM-413), and arrange for their transfer to other Navy blood regions, Federal facilities, or local civilian blood banks, as directed.

(f) Advise COMNAVMECOM (MEDCOM-413) of requirements that cannot be met within a region for appropriate action.

(g) If frozen blood component capabilities exist, maintain a stockpile of Cryoprecipitated Antihemophilic Factor (Human) of 50 units over the predicted day-to-day patient requirements and coordinate the production, storage, and inventory reporting of cryoprecipitates by other area blood service units, as necessary.

(h) When directed by COMNAVMECOM, coordinate freezing and storage of red blood cells for shipment to appropriate Navy ships or frozen blood depots.

(i) Make recommendations to COMNAVMECOM concerning the improvement of area blood operations.

(j) Screen all area contractual agreements for the exchange of unexpired blood products and recommend appropriate COMNAVMECOM actions.

(k) Perform public information functions for the region and act as COMNAVMECOM representative in dealing with local community blood banks.

(l) In conjunction with nonmedical authorities, act upon requests by civilian blood banks for use of area blood donor populations following OPNAVINST 6530.2 series.

(m) Receive, collate, analyze, and take appropriate corrective managerial actions on blood bank operational reports from all area blood system units.

(n) Prepare a quarterly consolidated Blood Bank Operational Report, NAVMED 6530/1, or appropriate DOD equivalent, for all area blood system units and forward this consolidated report, along with copies of all system blood service unit reports, to COMNAVMECOM (MEDCOM-413). Provide copies of these submissions to the regional NAVMEDCOM with cognizance over the submitting area blood system director.

(o) Visit each component area blood bank or donor center annually, and submit a copy of the FDA Inspection Checklist completed during such technical assistance visits to COMNAVMECOM (MEDCOM-413) following NAVMEDCOMINST 6530.2 series. Provide copies of these submissions to the regional NAVMEDCOM with cognizance over the visited and visiting activities.

(3) Area Blood Service Units (48 Contiguous United States).-

(a) Comply with mission and function requirements in NAVMEDCOM Instructions 6530 series.

(b) Comply, as applicable, with the requirements of the Bureau of Biologics, Food and Drug Administration, NAVMED P-5101, NAVMED P-5120, and NAVMED P-5123.

(c) Maintain a blood procurement program designed to meet both routine and emergency blood product requirements to the full extent of in-house capability using the area blood system coordinator as a secondary source of support. This program will be capable of providing short-notice supplemental support for other area facilities and contingencies as stated in the COMNAVMECOM Logistics Support and Mobilization Plan or as otherwise directed.

(d) Maintain a blood inventory control system capable of providing data required by COMNAVMECOM (and the area blood system coordinator, where applicable) for the effective use of blood resources.

(e) Advise the area blood system director of predicted blood product excesses or deficiencies following the director's reporting policies. Make arrangements for intra or interregional shipments of excess blood products to Navy or other Federal and civilian activities as directed.

(f) Use standard blood bank forms and blood-product labels as directed.

(g) Submit the original plus one copy of NAVMED 6530/1, Blood Bank Operational Report, or appropriate DOD equivalent, to the Area Blood System director quarterly as directed by COMNAVMECOM.

(h) Ensure technician proficiency in blood bank techniques.

(i) Arrange for emergency blood product support from nearby Federal or civilian sources.

(4) Other Blood Service Units.-

(a) Comply with mission and function requirements in NAVMEDCOM Instructions 6530 series.

(b) Comply, as applicable, with the requirements of the Bureau of Biologics, Food and Drug Administration, NAVMED P-5101, NAVMED P-5120, and NAVMED P-5123.

(c) Maintain a blood procurement program designed to meet both routine and emergency blood product requirements to the full extent of in-house capability. This program will be capable of providing short-notice supplemental support for other area facilities and contingencies as directed.

(d) Maintain a blood inventory control system capable of providing data required for in-house assessment and for completion of NAVMED 6530/1 or appropriate DOD equivalent.

(e) Use standard blood bank forms and blood product labels as directed.

(f) Submit original of NAVMED 6530/1, Blood Bank Operational Report, or appropriate DOD equivalent, as directed by COMNAVMECOM to MEDCOM-413.

(g) Ensure technician proficiency in blood bank techniques.

14-11. Related Information Sources

6530/1 or Appropriate DOD Equivalent.-Submit quarterly in following guidance given above.
 (2) Related Publications.-

(1) Blood Bank Operational Report, NAVMED

Number	Title	Stockpoint
NAVMED P-5101	Technical Manual of the American Association of Blood Banks	Navy Supply System
NAVMED P-5120	Standards for Blood Banks and Transfusion Services	Navy Supply System
NAVMED P-5123	Operational Procedures for Military Blood Donor Centers and Armed Services Whole Blood Processing Laboratories	Navy Supply System
.....	Code of Federal Regulations, title 21, parts 600-1299	Government Printing Office

(3) Related Directives and Instructions.-

DOD Directive 6480.5	Military Blood Program	Navy Supply System
DOD Instruction 6480.4	DOD Blood Program-Mobilization Planning Factor, Whole Blood, and Colloids	Navy Supply System
OPNAVINST 6530.2 series	Navy Blood Program	Navy Supply System
NAVMEDCOMINST S4820.1 series	Logistics Support and Mobilization Plan	Navy Supply System
NAVMEDCOMINST 6530.1 series	Navy Blood Program	Navy Supply System
NAVMEDCOMINST 6530.2 series	Organization of the Regionalization of the Navy Blood Service Units in the Continental United States Area	Navy Supply System

Section III. AEROSPACE MEDICINE

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14-12. Aerospace Physiology Training Program

(1) *Objectives.*—The Bureau of Medicine and Surgery directs the Aerospace Physiology Training Program. The objectives of the program are to:

(a) Provide definitive instruction in aerospace physiology (i.e., respiration, circulation, acceleration, spatial orientation, and vision), as it applies to the aircrew personnel and their survival.

(b) Provide instruction in the accepted operational procedures for the utilization of oxygen breathing systems, emergency egress systems, and aircrew personnel survival equipment.

(c) Provide swimming test, water survival training, and survival lectures in accordance with OPNAV instructions.

(d) Coordinate fleet introduction and evaluation of aviation personal protective and safety equipment between Naval Air Systems Command and selected fleet aviation activities.

(e) Conduct evaluation of aircrew protective equipment in accordance with assigned tasks.

(f) Assist the flight surgeon and aviation fleet personnel with aircraft and life support equipment anthropometric compatibility assessments.

(2) *Courses.*—BUMED approves training courses developed by the aviation training model manager as required to meet the objectives of OPNAVINST 3710.7 series.

(3) *Facilities.*—The facilities utilized to meet the objectives of the training program are:

(a) Aerospace physiology training units (APTU's) located at selected air stations and hospitals.

(b) Selected Navy laboratories and test facilities.

(4) *General.*—Strict adherence to applicable operation and maintenance handbook procedures on all training devices used in the Aerospace Physiology Training Program must be practiced in the interest of safety.

14-13. Responsibilities of Aerospace Physiology Training Unit Personnel

(1) Aerospace physiologists shall have at least a Bachelor of Science degree in biology or a related science. They shall also have successfully completed the course of training for aerospace physiology at the

NAVAEROSPMEDINST, and the familiarization and indoctrination in basic flight and ground training prescribed by the Chief of Naval Air Training which also includes swimming, sea survival, and land survival. Aerospace physiologists, when designated, are authorized to wear the appropriate insignia as prescribed in the Navy Uniform Regulations and to receive career incentive pay when ordered to a duty involving a flying operations billet.

(2) Aerospace physiologists (NOBC-0849) shall:

(a) Be responsible for the efficient operation and effective resource management of the APTU's.

(b) Coordinate the training program with all organizations and personnel concerned with its effective accomplishment.

(c) Instruct in aerospace physiology and supervise all indoctrination/refresher training within the APTU, and supervise and be responsible for the safe operation of all physiological training devices under their control.

(d) Conduct fleet introduction and evaluation of aviator's personal and survival equipment in accordance with AIRTASKS assigned to the APTU.

(e) Maintain adequate records on all training, all AIRTASK assignments, and all maintenance procedures.

(f) Be responsible, because of their specialized training, for the proper management and supervision of any emergency incurred during training or testing events.

(g) Provide consultation services on aeromedical consideration of human factors in aviation safety and accident prevention to flight surgeons and aviation safety officers.

(3) Aerospace physiology technicians (NEC-8409) shall:

(a) Serve as a technical assistant to the aerospace physiologist in the overall objectives of the APTU to which they are assigned.

(b) Instruct in oxygen equipment, emergency egress systems, visual problems, low pressure chambers, personal survival equipment, and water survival, as required and assigned.

(c) Maintain a proficiency in administrative duties peculiar to the requirements of the training program.

(d) Be thoroughly knowledgeable in the management of emergencies and injuries incurred as a result of low pressure chamber, ejection seat, or water training activity.

(4) Parachute riggers (aircrew survival equipment man) (NEC-7312) shall:

(a) Maintain personal survival equipment used by the APTU such as oxygen masks, protective helmets, anti-exposure garments, life rafts, and life preservers. They shall conduct preventive maintenance schedules on all life support equipment associated with low pressure chambers, ejection seat trainers, and water survival trainers.

(b) Instruct in oxygen equipment and personal protective and survival equipment.

(5) TRADEVMAN (NEC-7533 or civilian equivalent) shall:

(a) Operate training devices assigned to the APTU.

(b) Conduct a prescribed preventive maintenance schedule on these devices.

(c) Be responsible for the indoctrination and training of newly assigned TRADEVMEN.

14-14. Complement of an Aerospace Physiology Training Unit

(1) The normal minimum complement is determined by the physiological training devices assigned and the workload of the training unit.

Title	NOBC/NEC	Minimum Requirement
Aerospace Physiologist	0849	1
Aerospace Physiology Technician	8409	
With Device 9A1/9A2		4
With Device 9A1C/9U44B		5
With Device 9A9		6
Aircrew Survival Equipment		
Man	7312	1
TRADEVMAN	7533	2

(2) Activities conducting water survival training under CNO cognizance shall require additional personnel qualified as water safety instructors and Navy divers. In addition, one TRADEVMAN (NEC-7533) shall be required to operate and maintain the devices associated with the water program.

14-15. Student Restrictions to Aerospace Physiology Training

(1) Restrictions to aerospace physiology training for students shall be as noted in OPNAVINST 3710.7 series.

(2) Prior to indoctrination in any phase of the training program, aerospace physiologists shall screen all trainees for any condition which would contraindicate participation in the low pressure chamber flight, ejection seat trainer shot, or water training. They shall refer all questionable instances to a flight surgeon for clearance.

14-16. Reports and Forms

(1) *Aerospace Physiology Training Report (Report Symbol MED 6410-3).*—A single copy of this

report shall be submitted on NAVMED 6410/3 to BUMED at the end of each quarter by each activity at which aerospace physiology training is accomplished.

(2) *Report of Injury.*—In the event of any personal injury incurred during training, a report and supporting document shall be submitted in accordance with instructions on NAVMED 6410/3.

(3) *Altitude Chamber Reaction Report (NAVMED 6410/4).*—A single copy of this form for each incident shall be completed in full in accordance with the instructions on NAVMED 6410/3 and submitted to BUMED at the end of each quarter as an enclosure to report MED 6410-3. Chamber reactions which require admission to the sicklist will be reported by message to BUMED.

(4) *Training Forms.*—Forms of record used in the Aerospace Physiology Training Program shall be uniform as established by the Bureau of Medicine and Surgery, Aerospace Physiology Branch. These forms are as follows:

NAVMED Form	Title	Stocking Point
6410/3	Aerospace Physiology Training Report	BUMED
6410/4	Altitude Chamber Reaction Report	BUMED
6410/5	Student Screening Form	Navy Supply System
6410/6	Aerospace Physiology Training Agreement	BUMED
6410/7	Completion of Training Certificate	Navy Supply System
6410/8	Aerospace Physiology Training and Low Pressure Chamber Flight Log	Navy Supply System

(5) *Special Medical Abstract (NAVMED 6150/2).*—Entries made on this form, having applica-

tion to the Aerospace Physiology Training Program, shall be uniform as established by article 16-59.

Chapter 15

PHYSICAL EXAMINATIONS

SECTIONS

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Section I. PHYSICAL STANDARDS

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15-1. Responsibility for Prescribing Standards

(1) The Chief, Bureau of Medicine and Surgery takes the initiative in the development of physical standards for enlistment in the United States naval service. While the Bureau of Medicine and Surgery takes the initiative in the development, the standards represent the concurrence of all the interested communities within the Department of the Navy, and the Commandant of the Marine Corps where applicable.

15-2. Purpose of Physical Standards

(1) No person shall be enlisted, appointed, or commissioned who does not conform to the physical standards prescribed by the Chief, Bureau of Medicine and Surgery.

(2) Physical standards are established to secure uniformity in conducting physical examinations and in interpreting physical fitness of candidates for, and persons in, the naval service. The object is to procure and retain personnel who are physically fit and temperamentally adaptable to the conditions of military life. This is intended to preclude from acceptance those individuals who present contagious or infectious disease which would be likely to endanger the health of other personnel; those who are likely to require repeated admissions to the sicklist, prolonged hospitalization, or invaliding from service; and those who present any condition which would be likely to form the basis of a claim for physical retirement benefits. The standards, therefore, are intended to delineate a degree of physical fitness in acceptable applicants that will best meet the needs of the naval service and yet involve an acceptable minimum of incurred risk as concerns liability in regard to health hazards, repeated or prolonged medical care or hospitalization, assignment problems, and eventual pension or retirement benefits. This required degree of physical fitness is correlated with the available supply of applicants for military service and normal service needs. Depending upon the personnel needs of the naval service at any given time, these standards are subject to change.

15-3. Application of Physical Standards

(1) To determine whether the applicant for enlistment, appointment, or commission meets the prescribed standards, he or she shall be physically examined. All applicants for entry into the naval service shall be required to conform to these physical standards as they apply to the program and grade or rate involved. In applying these basic standards set forth herein, the examiner should consult current directives pertaining to the particular program involved for further orientation as to policy applications. Any applicant who does not conform to the

standards shall be rejected unless a waiver is obtained (see sec. III of this chapter). In submitting a recommendation for waiver it must be understood there are certain physical defects which under the established standards are absolutely disqualifying for appointment to commissioned grade or enlistment (example: loss of an extremity or of useful vision); whereas there are defects which are considered to be disqualifying but for which a recommendation for waiver may be appropriate. In the latter category are such defects as dental caries; absence acquired, teeth; hernia; flat feet; or certain degrees of defective vision. The decision as to whether such defects are disqualifying rests upon many considerations, including the amount of investment by the Government in the applicant, the need of the naval service for such additional personnel at the time of consideration, the relative professional qualifications of the applicant, and equity responsibilities of the service.

(2) To be acceptable an applicant must possess the physical and mental fitness and the personality and behavior characteristics necessary for adjustment to service life. The total fitness of the applicant shall be carefully considered in relation to the character of the duties which the applicant may be called upon to perform. The examiner must appreciate the difference in requirements between applicants for various programs. An applicant for an expensive long-term training program (for instance, admission to the Naval Academy, or the regular NROTC program, which are designed to produce line officers) must meet a higher standard of physical fitness than an applicant who is to be accepted for a short-term period of service. The presence of slight defects in those who have matured may be of less import than in less mature persons and may not necessarily be cause for rejection. Slight physical defects in applicants who have had prior military service have less significance than in those who have not demonstrated their ability to function satisfactorily under service conditions.

(3) In general, it is considered that relatively minor defects which would be disqualifying for original commission direct from civilian life are not disqualifying for appointment of an applicant from an officer candidate training program such as the Naval Reserve Officers Training Corps (Regular); the U.S. Naval Academy; or the Platoon Leaders Class, U.S. Marine Corps. Similarly, minor defects which would be disqualifying for original commission direct from civilian life are not disqualifying for appointment of an applicant from temporary commissioned grade or from Reserve status to commissioned grade in the Regular Navy or Marine Corps, provided such an applicant has matured sufficiently and has demonstrated by satisfactory service that the defect or disability has not interfered with the applicant's performance of duty. In situations involving applicants for Marine Corps officer candidate programs on

appointment to commissioned grade, it should be borne in mind that all newly commissioned Marine officers, Regular and Reserve, initially are expected to be able to perform all duties normally required under field conditions of infantry officers or pilots, as appropriate.

(4) The physical defects or disabilities of applicants for reenlistment (see art. 15-30) which ordinarily would be cause for rejection for original enlistment are a proper subject for request of waiver, provided it has been demonstrated that the defect or disability did not interfere with the performance of duty during the original enlistment. However, upon immediate reenlistment following discharge from the Regular service, request for waiver is not required for defects or disabilities incurred as the proximate result of service provided the individuals concerned can perform the duties of their office, grade, or rating.

15-4. Interpretation of Physical Standards

(1) Medical examiners should interpret the standards with discretion and should not construe them too arbitrarily. They should, however, avoid a tendency to find qualified the individual who is able to meet a particular requirement only after coaching or under unusual circumstances. In determining visual acuity, blood pressure, or pulse rate, for example, the mean performance should be considered in recommending acceptance or rejection of the applicant. The conditions listed herein as causes for rejection may be absolutely disqualifying or only relatively disqualifying, dependent upon the nature of the defect, its significance in the individual applicant, and the program for which the applicant is being examined. Examiners are expected to use discretion in evaluating the degree of severity of any defect or disability, but are not authorized to disregard defects or disabilities which are disqualifying in accordance with the standards. In the event a defect listed herein as cause for rejection is considered not disqualifying in a particular applicant, the examiner should set forth the reasons therefor.

15-5. Medical History

(1) In order to assist the examiner in conducting the physical examination and in applying the physical standards, it is required that a history be carefully obtained. An applicant for entry into the naval service, upon reporting for examination, shall first be required to complete Standard Form 93 (Report of Medical History). The data on the completed form shall be reviewed; positive answers commented on; and elaborated upon by the examiner whenever it is necessary to present a more complete picture of the individual's medical history.

(2) The complete history of the examination shall be inquired into. The following outline is indicative of the scope of such inquiry:

(a) *General History.*—

(1) *Early Development.*—Birth injuries and deformities. Age when bedwetting ceased, when walking began, and when talking began. Neurotic traits. Childhood characteristics.

(2) *Home Environment.*—Family harmony. Attitude toward parents and siblings. Treatment by parents and others. Broken home. Conflicts with stepmother or stepfather. Ran away from home; reasons.

(3) *Education.*—Final grade completed; at what age. Progress. Reasons for failures. Conflict with teachers or schoolmates. Truancy. Reasons for leaving school.

(4) *Industrial.*—Positions held. Wages received. Length of employment in each job. Efficiency at work. Economic adjustment.

(5) *Past Medical History.*—Diseases, injuries, and operations from infancy to present time in chronological order, with particular references to previous attacks of mental illness or nervous disorder.

(6) *Habits.*—Use of, and reaction to, alcohol and drugs. Diet, tobacco, coffee, sleep, exercise, recreation, etc.

(7) *Sex life.*—Excessive or prolonged masturbation. Associated conflicts and guilt feelings. Any changes in sexual powers or interests. Impotence. Homosexual tendencies or overt acts. Perversions.

(8) *Marital.*—Date of marriage. Number of marriages. Health of spouse. Number of children. Stillbirths and miscarriages. Separation or divorce.

(9) *Antisocial Conduct.*—Juvenile offenses. Residence in reformatory. Attitude toward authority. Arrests in adult life. Prison and jail sentences. Nomadism, hoboism.

(10) *Military.*—Combat experience; when and where. Courts martial; for what offenses. Any disciplinary action pending. Attitude toward the service. Promotions. Special duties. Previous service in other branches of the military; dates; reason for discharge.

(b) *Personality History.*—Information should be obtained regarding output of energy, ambition, perseverance, moods, general relationships with other people, sociability, likes and dislikes, eccentricities, tolerance, conscientiousness, sensitivity, sense of humor, affiliation with religious cults, rigidity and perfectionism, seclusiveness, and feelings of inadequacy or inferiority.

(c) *Family History.*—The presence of mental disease, neurological disorders, chronic invalidism, neurotic traits, epilepsy, personality disorders, disorders of intelligence, criminality, suicide, drug addiction, alcoholism, syphilis, tuberculosis, diabetes, cancer, kidney disease, heart disease, stomach

disease, arthritis/rheumatism, asthma, hay fever, and hives in the parents, siblings, and other collateral lines should be inquired into.

15-6. Physical Standards for Entrance Into the Naval Service

(1) Articles 15-8 through 15-28 set forth the physical standards for entrance into the naval service, except the physical standards for enlistment which are set forth in article 15-30. Where the standards differ for different groups of personnel as in male and female, Regular and Reserve, Navy and Marine Corps, the differences will be noted under the particular system or in separate articles in this chapter. In addition to the statement of the standard, there is included under each system a list of causes for rejection and where indicated, a brief résumé of the method for conducting the examination. The lists of causes for rejection are not intended to be complete, but are representative. A specific cause for rejection as listed is usually to be considered disqualifying while such condition persists. When it is necessary to describe the method of examination at length, reference will be made to a specific article in section VIII of this chapter.

(2) If an applicant is regarded by the medical examiners as physically unfit for naval service by reason of a condition not specifically noted in the succeeding articles as a cause for rejection, he or she shall, nevertheless, be rejected, and a full statement of the reason therefor entered on the report.

(3) The term "medical examiners" as used in this chapter shall be construed to include an officer of the Dental Corps when assigned to the duty of conducting the dental examination part of a physical examination. Likewise, the term "physical examination" shall be construed to include the dental examination unless otherwise indicated.

15-7. Retention Criteria

(1) In general, the physical standards contained in this chapter are to be interpreted as applicable only to initial entry into the Navy and Marine Corps or entry into special programs, and should not be utilized as a basis for finding a member not physically qualified, or physically unfit for retention or immediate reenlistment. A member ordinarily is considered fit for duty unless there is a physical disability or a combination of physical disabilities which interfere with the performance of the duties which the member may reasonably be expected to perform by virtue of grade or rating. Each instance must be decided upon the relevant facts, and a determination of fitness or unfitness must depend upon the individual's ability to perform the duties of grade or rating in such manner as to fulfill reasonably the purpose of the member's employment on active duty.

(2) Once a member has been enlisted or commissioned, such factors as: (a) inability to meet the physical standards for initial entry into the service; (b) pending voluntary or involuntary separation or retirement or release to an inactive status; or (c) inability to physically qualify for specialized duty—are not to be used as a basis for considering a member not physically qualified or physically unfit for retention in the naval service.

(3) After a member has been enlisted, appointed, or commissioned, such member will not be declared unfit for naval service because of disabilities which existed at the time of acceptance for naval service and (a) which have remained essentially the same in degree since acceptance and (b) have not interfered with the member's performance of effective naval service. Under such circumstances, the propriety of initial acceptance into the naval service of an individual who did not meet entry physical standards is not at issue.

(4) Members who are considered temporarily or permanently unfit for duty should be referred to a medical board for appropriate disposition. For further guidance and information refer to SECNAVINST 1850.3 series, the Disability Evaluation Manual (SEC NAVINST 1850.4), and chapter 18 of this Manual.

15-8. Abdomen and Gastrointestinal System

(1) The abdomen shall be examined by inspection and palpation and, if necessary, by percussion and auscultation. When indicated, X-ray study and laboratory tests shall be made.

(2) The following are causes for rejection:

(a) Cholecystectomy, sequelae of, such as postoperative stricture of the common bile duct, reforming of stones in hepatic or common bile ducts, or incisional hernia, or postcholecystectomy syndrome when symptoms are so severe as to interfere with normal performance of duty.

(b) Cholecystitis, acute or chronic, with or without cholelithiasis, if diagnosis is confirmed by usual laboratory procedures or authentic medical records.

(c) Cirrhosis regardless of absence of manifestations such as jaundice, ascites, or known esophageal varices, abnormal liver function tests with or without history of chronic alcoholism.

(d) Fistula in ano.

(e) Gastritis, chronic hypertrophic, severe.

(f) Hemorrhoids:

(1) External hemorrhoids producing marked symptoms.

(2) Internal hemorrhoids, if large or accompanied with hemorrhage or protruding intermittently or constantly.

(g) Hepatitis within the preceding 6 months, or persistence of symptoms after a reasonable period

of time with objective evidence of impairment of liver function.

(h) Hernia:

(1) Hernia other than small asymptomatic umbilical or hiatal.

(2) History of operation for hernia within the preceding 60 days.

(i) Intestinal obstruction, or authenticated history of more than one episode, if either occurred during the preceding 5 years, or if resulting condition remains which produces significant symptoms or requires treatment.

(j) Megacolon of more than minimal degree, diverticulitis, regional enteritis, and ulcerative colitis. Irritable colon of more than moderate degree.

(k) Pancreas, acute or chronic disease of, if proven by laboratory tests, or authenticated medical records.

(l) Rectum, stricture or prolapse of.

(m) Resection, gastric or of bowel; or gastroenterostomy; however minimal intestinal restriction in infancy or childhood (for example: for intussusception or pyloric stenosis) is acceptable if the individual has been asymptomatic since the resection and if surgical consultation (to include upper and lower gastrointestinal series) gives complete clearance.

(n) Scars:

(1) Scars, abdominal, regardless of cause, which show hernial bulging or which interfere with movements.

(2) Scar pain associated with disturbance of function of abdominal wall or contained viscera.

(o) Sinuses of the abdominal wall.

(p) Splenectomy, except when accomplished for the following:

(1) Trauma.

(2) Causes unrelated to diseases of the spleen.

(3) Hereditary spherocytosis.

(4) Disease involving the spleen when followed by correction of the condition for a period of at least 5 years.

(q) Tumors. (See art. 15—27.)

(r) Ulcer:

(1) Ulcer of the stomach or duodenum, if diagnosis is confirmed by X-ray examination, or authenticated history thereof.

(2) Authentic history of surgical operation(s) for gastric or duodenal ulcer.

(s) Other congenital or acquired abnormalities and defects which preclude satisfactory performance of military duty or which require frequent and prolonged treatment.

15—9. Blood and Blood-Forming Tissue Diseases

(1) The following are causes for rejection:

(a) Anemia:

(1) Blood loss anemia—until both condition and basic cause are corrected.

(2) Deficiency anemia, not controlled by medication.

(3) Abnormal RBC destruction. Hemolytic anemia.

(4) Abnormal RBC construction: Hereditary hemolytic anemia, thalassemia, and sickle cell anemia.

(5) Myelophthisic anemia: Myelomatosis, leukemia, Hodgkin's disease.

(6) Primary refractory anemia: Aplastic anemia, di Guglielmo's Syndrome.

(b) Hemorrhagic states:

(1) Due to changes in coagulation system (hemophilia, etc.).

(2) Due to platelet deficiency.

(3) Due to vascular instability.

(4) History of hemorrhagic states if:

(a) More than one acute episode has occurred.

(b) Less than 7 years have elapsed since evidence of single acute attack.

(c) Less than 7 years have elapsed since splenectomy for hemorrhagic condition.

(c) Leukopenia, chronic or recurrent, associated with increased susceptibility to infection.

(d) Myeloproliferative disease (other than leukemia):

(1) Myelofibrosis.

(2) Megakaryocytic myelosis.

(3) Polycythemia vera.

(e) Splenomegaly until the cause is remedied.

(f) Thromboembolic disease except for acute, nonrecurrent conditions.

15—10. Dental

(1) *Purpose of Dental Standards.*—The purpose of dental standards for entry into the Navy or Marine Corps is to:

(a) Assure that persons who enter the naval service do not have serious dental defects which would permanently and significantly interfere with the performance of the duties which are expected of them.

(b) Assure that candidates for original appointment as commissioned officers do not require extensive dental treatment which will necessitate frequent or prolonged absence from primary duties.

(c) Assure that candidates for officer training programs possess a reasonable level of dental health and do not require dental treatment which will significantly interfere with their participation in the training programs.

(d) Limit, when feasible, the amount of dental treatment needed by persons entering the naval service. This is desirable since the strength of the Dental Corps is limited by law to a number which is insufficient to provide all the dental treatment required by active duty personnel.

(2) *General Provision of Dental Standards and Dental Examinations.*—

(a) All dental examinations should be performed, when possible, by dental officers of the Navy or the Naval Reserve, even though the latter may not be serving on active duty. When a dental officer is not available, dental examinations of persons, other than applicants for admission to the U.S. Naval Academy as midshipmen, and candidates for flight training (arts. 15-70(8) and 15-76(2) apply), may be performed by naval medical officers.

(b) The dental examiner shall indicate on the examination form whether or not the examinee meets the dental standards which apply. Whenever an examinee does not meet the standards which apply for a specific examination, the dental examiner shall enter a detailed description of the disqualifying condition.

(3) *Application of Dental Standards.*—The dental standards shall apply to all persons entering the U.S. Navy, U.S. Naval Reserve, U.S. Marine Corps, and U.S. Marine Corps Reserve.

(4) *Standards for Promotion of an Officer.*—See BUPERSMAN 2220150, or MARCORPERSMAN paragraph 6201.

(5) *Standards for the Dental Portion of the Triennial/Annual Physical Examination of an Officer.*—A dental examination shall be conducted as a part of this physical examination of a commissioned or warrant officer who is on active duty. Conservation and promotion of oral health is the principal objective of this dental examination. When oral disease or dental defects are discovered, the dental examiner shall make suitable recommendations for the institution of corrective measures.

(6) *Dental Standards for Duty on a Ship or at a Station Not Having a Dental Officer.*—Whenever practicable, officers and enlisted personnel who are being transferred to ships or stations where the services of a naval dental officer will not be available shall be referred to a naval dental officer for an examination and necessary treatment before proceeding to such ships or stations for duty.

(7) *Standards for All Categories of Women.*—To be accepted for appointment, a candidate shall meet the same requirements as those prescribed for men.

(8) *Standards for Appointment to Warrant or Commissioned Grade.*—To qualify for appointment to warrant or commissioned grade, an applicant must have sufficient teeth, natural or artificial, in functional conclusion to ensure satisfactory incision and mastication.

(9) *Standards for Appointment, Enrollment, or Enlistment as Midshipmen, Naval Academy; Naval Aviation Cadet; Aviation Officer Candidate; Officer Candidate and Midshipman, Merchant Marine Reserve; Regular and Contract Student, Naval Reserve Officers Training Corps; Naval Academy Preparatory School; Reserve Officer Candidate Course; Platoon Leaders Class and Officers Candidate Course, U.S.*

Marine Corps Reserve; Officer Candidate School, U.S. Naval Reserve; and Other Similar Officer Candidate Training Programs.—

(a) The dental examiner shall become familiar with article 15-3.

(b) A candidate for appointment to one of the above listed officer candidate training programs must have a minimum of 16 natural permanent teeth of which a minimum of 8 must be in each arch. Such a candidate must have all missing teeth which cause unsightly spaces or significantly reduced masticatory or incisal efficiency replaced by bridges or partial dentures which are well designed and in good condition, except for civilian aviation officer candidates and certain enlisted personnel. (See par. (c)(2) below.) Such a candidate must have received all required dental treatment including permanent restoration of teeth damaged by dental caries except minor or questionable carious areas.

(c) The following are causes for rejection:

(1) Apical or periodontal infection which requires the removal and extensive replacement of teeth.

(2) Carious teeth except for minor or questionable carious areas. Civilian aviation officer candidates with dental conditions not requiring immediate or extensive treatment may be considered dentally qualified. Active duty enlisted personnel who are candidates should not be disqualified for caries but appointments arranged for remedial treatment.

(3) Failure to have a minimum of eight natural permanent teeth in each arch.

(4) Infectious or chronic diseases of the soft tissue of the oral cavity.

(5) Lack of satisfactory incisal or masticatory function.

(6) Marked malocclusion which requires early or prolonged treatment, involves tissue impingement on either the facial or lingual/palatal gingiva, or in other ways jeopardizes oral health.

(7) Retainer type orthodontic appliances are permissible. Orthodontic appliances attached to teeth for continued treatment are disqualifying except as noted below:

(a) Candidates for the Naval Academy undergoing active orthodontic treatment will not be disqualified by the examining dental officer. Examinations shall be performed in accordance with BUMEDINST 6120.3 series and appropriate comments shall be made in section 74 of the SF 88 for review by the Department of Defense Medical Review Board.

(b) Candidates for the Naval Reserve Officer Training Corps undergoing active orthodontic treatment will be considered on the basis of a certifying statement concerning completion date of treatment by the individual's orthodontist.

(8) Perforations from the oral cavity into the nasal cavity or maxillary sinus.

(9) Tumors or cysts of the oral cavity which require treatment or may require treatment in the foreseeable future.

(10) Unreplaced teeth which cause unsightly or significantly reduced masticatory function.

(11) Unsatisfactory restorations, bridges, or dentures.

15-11. Ears and Hearing

(1) The external ear and mastoid region shall be examined by inspection, the mastoid region by palpation for signs of disease. The external auditory canal and tympanic membrane shall be examined by reflected light or by a self-illuminating otoscope. Cerumen, if present, must be removed prior to attempt to visualize the tympanic membrane and prior to determination of auditory acuity. Auditory acuity shall be determined by audiogram in each instance.

(2) *The Ears.*—The following are causes for rejection:

(a) Auditory canal:

(1) Atresia or severe stenosis of the external auditory canal.

(2) Tumors of the external auditory canal except mild exostoses.

(3) Severe external otitis, acute or chronic.

(b) Auricle: Agenesis, severe; or severe traumatic deformity, unilateral or bilateral.

(c) Mastoids:

(1) Mastoiditis, acute or chronic.

(2) Residual of mastoid operation with marked external deformity which precludes or interferes with the wearing of a gas mask or helmet.

(3) Mastoid fistula.

(d) Meniere's syndrome.

(e) Middle ear:

(1) Acute or chronic suppurative otitis media. Individuals with a recent history of acute suppurative otitis media will not be accepted unless the condition is healed and a sufficient interval of time subsequent to treatment has elapsed to ensure that the disease is in fact not chronic.

(2) Adhesive otitis media associated with hearing level by audiometric test in excess of the standards in subarticle 15-11(3).

(3) Acute or chronic otitis media.

(4) Presence of attic perforation in which presence of cholesteatoma is suspected.

(5) Repeated attacks of catarrhal otitis media; intact greyish, thickened drum(s).

(f) Tympanic membrane:

(1) Any perforation of the tympanic membrane.

(2) Severe scarring of the tympanic membrane associated with hearing level by audiometric test in excess of the standards in subarticle 15-11(3).

(3) Surgery to repair perforated tympanic membrane within the past 120 days.

(g) The total loss of an external ear, marked hypertrophy or atrophy, disfiguring deformity of the organ, or any acute or chronic disease of the external, middle, or internal ear.

(3) *Hearing.*—An auditory acuity level in either ear by audiogram in excess of the limits in the following table is disqualifying for commissioning:

International Standards Organization (ISO)

Frequency (hz)	500	1000	2000	3000	4000	8000
	512	1024	2048	2896	4096	8192
Maximum level in decibels in either ear.	Average level in these three frequencies not greater than 30 db with no level greater than 35 db in any one frequency.					
			45 db	60 db	*	

*Recorded for baseline information only.

15-12. Endocrine and Metabolic Disorders

(1) Endocrine and metabolic disorders are so varied in their manifestations and frequently so interrelated that recognition of the pathological process is often difficult. In this field the diagnostician has become increasingly dependent upon laboratory investigations for aid in corroboration of a clinical diagnosis. It should be emphasized that an accurate and comprehensive medical history may be of great value in pointing to subclinical endocrine or metabolic disorders. If sugar is found in the urine, further specimens, voided in the presence of the physician or authorized assistant, should be examined. In doubtful situations and in the presence of diabetes mellitus in a parent, sibling, or more than one grandparent, appropriate laboratory tests shall be made to rule out the presence of diabetes. (See art. 15-105.)

(2) The following are causes for rejection:

(a) Adrenal gland, malfunction of, of any degree.

(b) Cretinism.

(c) Diabetes mellitus or a history of diabetes mellitus in both natural parents. (See art. 15-12(1) regarding other familial history.)

(d) Diabetes insipidus.

(e) Gigantism or acromegaly.

(f) Glycosuria, persistent, regardless of cause.

(g) Goiter:

(1) Simple goiter with definite pressure symptoms or so large in size as to interfere with the wearing of a military uniform or military equipment.

(2) Thyrotoxicosis.

- (h) Gout.
- (i) Hyperinsulinism, confirmed symptomatic.
- (j) Hyperparathyroidism and hypoparathyroidism.
- (k) Hypopituitarism, severe.
- (l) Hypothyroidism, spontaneous or post-operative (with clinical manifestations and not based solely on low basal metabolic rate).
- (m) Nutritional deficiency diseases (including sprue, beriberi, pellagra, and scurvy) which are more than mild and not readily remediable or in which permanent pathological changes have been established.

(n) Other endocrine or metabolic disorders which obviously preclude satisfactory performance of duty or which require frequent and prolonged treatment.

15-13. Extremities

(1) *General*.—The extremities shall be carefully examined for deformities, old fractures and dislocations, amputations, partially flexed or ankylosed joints, impaired functions of any degree, varicose veins, and edema. The feet shall be especially examined for flatfoot, corns, ingrowing nails, bunions, deformed or missing toes, hyperhidrosis, bromhidrosis, color changes, and clubfoot. When any degree of flatfoot is found, the strength of the feet should be ascertained by requiring the applicant to hop on the toes of each foot for a sufficient time and by requiring the applicant to alight on the toes after jumping up several times. To distinguish between disqualifying and nondisqualifying degrees of flatfoot, the examiner shall consider the extent, impairment of function, progressive or stationary nature, appearance in uniform, and presence or absence of symptoms. In this connection, it should be remembered that it is usually not the flatfoot condition itself which causes symptoms, but an earlier state in which the arches are collapsing and the various structures are undergoing readjustment of their relationships. In reporting flatfoot, angles of excursion or limitations of motion, comparative measurements should be stated, and X-rays forwarded when made. The series of exercises described in article 15-99 will often bring to light defects of extremities not otherwise discernible.

(2) *Upper Extremities*.—The following are causes for rejection (also art. 15-13(4)):

(a) *Limitation of motion*. An individual will be considered unacceptable if the joint ranges of motion are less than the measurements listed below:

- (1) *Shoulder*:
 - (a) Forward elevation to 90°.
 - (b) Abduction to 90°.
- (2) *Elbow*:
 - (a) Flexion to 100°.
 - (b) Extension to 15°.

(3) *Wrist*: A total range of 15° (extension plus flexion).

(4) *Hand*: Pronation to the first quarter of the normal arc. Supination to the first quarter of the normal arc.

(5) *Fingers*: Inability to clench fist, pick up a pin or needle, and grasp an object.

(b) *Hand and fingers*:

(1) Absence (or loss) of more than 1/3 of the distal phalanx of either thumb.

(2) Absence (or loss) of distal and middle phalanx of index, middle, or ring finger of either hand irrespective of the absence (or loss) of little finger, absence of more than the distal phalanx of any two of the following fingers of either hand: Index, middle, or ring.

(3) Absence of hand or any portion thereof except for fingers as noted above.

(4) *Hyperdactylia*.

(5) Scars and deformities of the fingers and/or hand which impair circulation, are symptomatic, are so disfiguring as to make the individual objectionable in ordinary social relationships, or which impair normal function to such a degree as to interfere with the satisfactory performance of military duty.

(c) *Wrist, forearm, elbow, arm, and shoulder*: Healed disease or injury of wrist, elbow, or shoulder with residual weakness or symptoms of such a degree as to preclude satisfactory performance of duty.

(3) *Lower Extremities*.—The following are causes for rejection (also see art. 15-13(4)):

(a) *Limitation of motion*.—An individual will be considered unacceptable if the joint ranges of motion are less than the measurements listed below:

- (1) *Hip*:
 - (a) Flexion to 90°.
 - (b) Extension to 10° (beyond 0).
- (2) *Knee*:
 - (a) Full extension.
 - (b) Flexion to 90°.
- (3) *Ankle*:
 - (a) Dorsiflexion to 10°.
 - (b) Plantar flexion to 10°.
- (4) *Toes*: Stiffness which interferes with walking, marching, running, or jumping.

(b) *Foot and ankle*.—

(1) Absence or loss of:

(a) Any portion of the foot if function of the foot is poor or running or jumping is impaired.

(b) Great toe of either foot.

(c) Dorsal flexion of great toe(s) if function of the foot is impaired.

(d) Other toe(s) if function of the foot is poor or running or jumping is impaired.

(2) Claw toes precluding the wearing of combat service boots.

(3) Clubfoot.

(4) Flatfoot, pronounced instances, with decided eversion of the foot and marked bulging of the inner border, due to inward rotation of the astragalus.

(5) Flatfoot spastic.

(6) Hallux valgus, if severe and associated with marked exostosis or bunion.

(7) Hammer toe which interferes with the wearing of combat service boots.

(8) Healed disease, injury or deformity including hyperdactylia, which precludes running, is accompanied by disabling pain, or which prohibits wearing of combat service boots.

(9) Ingrowing toe nails, if severe, and not remediable.

(10) Obliteration of the transverse arch associated with permanent flexion of the small toes.

(11) Pes cavus with clawing of the toes, tenderness under the metatarsal heads, and calluses beneath the metatarsal heads.

(c) *Leg, knee, thigh, and hip.*—

(1) Dislocated semilunar cartilage, loose or foreign bodies within the knee joint, or history of surgical correction of same if:

(a) Within the preceding 6 months.

(b) Six months or more have elapsed since operation without recurrence, and there is instability of the knee ligaments in lateral or anteroposterior directions in comparison with the normal knee or there are abnormalities noted on X-ray; there is significant atrophy or weakness of the thigh musculature in comparison with the normal side; there is not acceptable active motion in flexion and extension; or there are other symptoms of internal derangement.

(2) Authentic history or physical findings of an unstable or internally deranged joint causing disabling pain or seriously limiting function. Individuals with verified episodes of buckling or locking of the knee who have not undergone satisfactory surgical correction or if, subsequent to surgery, there is evidence of more than mild instability of the knee ligaments in lateral and anteroposterior directions in comparison with the normal knee, weakness or atrophy of the thigh musculature in comparison with the normal side, or if the individual requires medical treatment of sufficient frequency to interfere with the performance of military duty.

(d) *General.*—

(1) Deformities of one or both lower extremities which have interfered with function to such a degree as to prevent the individual from following a physically active vocation in civilian life or which would interfere with the satisfactory completion of prescribed training and performance of military duty.

(2) Diseases or deformities of the hip, knee, or ankle joint which interfere with walking, running, or weight bearing.

(3) Pain in the lower back or leg which is intractable and disabling to the degree of interfering with walking, running, and weight bearing.

(4) Shortening of a lower extremity resulting in any limp of noticeable degree.

(4) *Miscellaneous.*—The following are causes for rejection (also see arts. 15-13(2) and (3)):

(a) Arthritis:

(1) Active or subacute arthritis.

(2) Chronic osteoarthritis or traumatic arthritis of isolated joints of more than minimal degree, which has interfered with the following of a physically active vocation in civilian life or which precludes the satisfactory performance of military duty.

(3) Documented clinical history of rheumatoid arthritis (atrophic arthritis).

(4) Traumatic arthritis of a major joint of more than minimal degree.

(b) Disease of any bone or joint, healed, with such resulting deformity or rigidity that function is impaired to such a degree that it will interfere with military service.

(c) Dislocation, old unreduced; substantiated history of recurrent dislocations of major joints; instability of a major joint, symptomatic and more than mild; or if, subsequent to surgery, there is evidence of more than mild instability in comparison with the normal joint, weakness, or atrophy in comparison with the normal side, or if the individual requires medical treatment of sufficient frequency to interfere with the performance of military duty.

(d) Fractures:

(1) Malunited fractures that interfere significantly with function.

(2) Ununited fractures.

(3) Any old or recent fracture in which a plate, pin, or screws were used for fixation and left in place and which may be subject to easy trauma; e.g., a tibial plate.

(e) Injury of a bone or joint within the preceding 6 weeks, without fracture or dislocation, of more than a minor nature.

(f) Muscular paralysis, contracture, or atrophy, if progressive or of sufficient degree to interfere with military service.

(g) Osteomyelitis, active or recurrent of any bone; or substantiated history of osteomyelitis of any of the long bones, unless successfully treated 2 or more years previously without subsequent recurrence of disqualifying sequelae as demonstrated by both clinical and X-ray evidence.

(h) Osteoporosis.

(i) Scars, neuromas; extensive, deep, or adherent scars of the skin and soft tissues or neuromas of an extremity which are painful, interfere with muscular movements, preclude wearing of military equipment, or show a tendency to break down.

(j) Chondromalacia, manifested by verified history of joint effusion, interference with function, or residuals from surgery.

15-14. Eyes and Vision

(1) General. —

(a) The Armed Forces National Research Council Vision Committee has formulated two manuals on methods of examination for use by the armed services. These manuals are incorporated in articles 15-93 and 15-94 (1) and (2).

(b) It is BUMED policy that statements from optometrists will be accepted on all matters pertaining to eye examinations, except those involving definitive diagnoses of diseases. If evidence of disease is reported, then the opinion of an ophthalmologist should be sought. See article 15-70 regarding special visual examinations for naval aviators.

(2) Special Examination Requirements. —

(a) *Candidates for Flight Training and Certain Naval Aviators.* — Refraction under cycloplegic is required for all candidates for flight training as indicated in 15-75(1)(b), and for certain naval aviators as indicated in 15-70(20).

(b) *Promotion.* — See MILPERSMAN 2220150, or MARCORPERSMAN, paragraph 6201.

(c) *Visual acuity less than 20/20.* — Each eye must have a manifest refractive error recorded in block 60 of SF-88.

(3) *The Eyes.* — The following are causes for rejection:

(a) Lids:

(1) Blepharitis, chronic more than mild. Individuals with acute blepharitis will be rejected until cured.

(2) Blepharospasm.

(3) Dacryocystitis, acute or chronic.

(4) Destruction of the lids, complete or extensive, sufficient to impair protection of the eye from exposure.

(5) Disfiguring cicatrices and adhesions of the eyelids to each other or to the eyeball.

(6) Growth or tumor of the eyelid other than small early basal cell tumors of the eyelids, which can be cured by treatment, and small non-progressive asymptomatic benign lesions. (See also art. 15-27.)

(7) Marked inversion or eversion of the eyelids sufficient to cause unsightly appearance or watering of eyes (entropion or ectropion).

(8) Lagophthalmos.

(9) Ptosis interfering with vision.

(10) Trichiasis, severe.

(b) Conjunctiva:

(1) Conjunctivitis, chronic, including vernal catarrh and trachoma. Individuals with acute conjunctivitis are unacceptable until the condition is cured.

(2) Pterygium:

(a) Pterygium recurring after three operative procedures.

(b) Pterygium encroaching on the cornea in excess of 3 millimeters or interfering with vision.

(c) Cornea:

(1) Dystrophy, corneal, or any type including keratoconus of any degree.

(2) Keratitis, acute or chronic.

(3) Ulcer, corneal; history of recurrent ulcers or corneal abrasions (including herpetic ulcers).

(4) Vascularization or opacification of the cornea from any cause which interferes with visual function or is progressive.

(d) *Uveal tract:* Inflammation of the uveal tract except healed traumatic choroiditis.

(e) Retina:

(1) Angiomatoses, phakomatoses, retinal cysts, and other congenito-hereditary conditions that impair visual function.

(2) Degenerations of the retina to include macular diseases, macular cysts, holes, and other degenerations (hereditary or acquired) affecting the macula. All types of pigmentary degenerations (primary and secondary).

(3) Detachment of the retina or history of surgery for same.

(4) Inflammation of the retina (retinitis or other inflammatory conditions of the retina to include Coats' disease, diabetic retinopathy, Eales' disease, and retinitis proliferans).

(f) Optic nerve:

(1) Congenito-hereditary conditions of the optic nerve or any other central nervous system pathology affecting the efficient function of the optic nerve.

(2) Optic neuritis, neuroretinitis, or secondary optic atrophy resulting therefrom or documented history of attacks or retrobulbar neuritis.

(3) Optic atrophy (primary or secondary).

(4) Papilledema.

(g) Lens:

(1) Aphakia (unilateral or bilateral).

(2) Dislocation, partial or complete, of a lens.

(3) Opacities of the lens which interfere with vision or which are considered to be progressive.

(h) Ocular mobility and motility:

(1) Diplopia, that interferes with visual function (i.e., may suppress).

(2) Nystagmus, pronounced.

(3) Strabismus of 40 prism diopters or more uncorrectable by lenses to less than 40 diopters.

(4) Strabismus of any degree accompanied by documented diplopia.

(5) Strabismus, surgery for the correction of, within the preceding 6 months.

(i) *Miscellaneous defects and diseases:*

- (1) Abnormal conditions of the eye or visual fields due to diseases of the central nervous system.
- (2) Absence of an eye.
- (3) Asthenopia severe.
- (4) Exophthalmos, unilateral or bilateral.
- (5) Glaucoma, primary or secondary.
- (6) Hemianopsia of any type.
- (7) Loss of normal pupillary reflex reactions to light or accommodation to distance of Adie's syndrome.
- (8) Loss of visual fields due to organic disease.
- (9) Night blindness associated with objective disease of the eye. Verified congenital night blindness.
- (10) Residuals of old contusions, lacerations, penetrations, etc., which impair visual function required for satisfactory performance of military duty.

- (11) Retained intra-ocular foreign body.
- (12) Tumors (see also art. 15-27).
- (13) Any organic disease of the eye or adnexa which threatens continuity of vision or impairment of visual function.

- (14) Complicated conditions requiring contact lens for adequate correction of vision such as keratoconus, corneal ulcers, or irregular astigmatism.

- (15) History of treatment by orthokeratology or radial keratotomy, one or both eyes.

(4) *Visual Acuity Standards.* —

(a) Binocular Visual Efficiency (BVE) is a system that considers the visual acuity of both eyes rather than each eye individually and is indicated in percentages. BVE is determined by measuring the applicant's Snellen notation visual acuity in each eye separately and then, by use of table 1, converting the Snellen notation to a percentage. The results of the Snellen notation shall continue to be recorded in item 59 of SF 88 and the corrected and uncorrected BVE shall be reported in item 73 of SF 88.

- (1) The minimum visual acuity requirements for male and female officer candidate training and for appointment to commissioned or warrant grade shall be as set forth in table 2; however, a recommendation for waiver may be submitted in accordance with section III, chapter 15, and will be considered in light of the current needs of the naval service.

(2) In addition to the visual acuity requirements, refractive error limits must not be exceeded for certain programs where the uncorrected BVE is less than 100%. These limits are presented in table 3.

(b) Refractive error standards necessitate measurement of spectacle lenses by lensometer or by a manifest refraction if the applicant does not possess corrective lenses or when present prescription does not correct vision to 100% BVE. Naval aviation programs leading to the designation of naval aviator will continue to require cycloplegic refraction. Visual acuity requirements for entry and retention in various aviation programs are contained in section V of this chapter.

Table 1. Binocular Visual Efficiency

		RIGHT EYE							
		20 20	20 30	20 40	20 50	20 70	20 100	20 200	20 400
LEFT EYE	20/20	100	98	96	94	91	87	80	76
	20/30	98	92	90	88	85	81	74	69
	20/40	96	90	84	82	79	75	68	64
	20/50	94	88	82	77	73	70	62	58
	20/70	91	85	79	73	64	60	53	49
	20/100	87	81	75	70	60	49	42	38
	20/200	80	74	68	62	53	42	20	16
	20/400	76	69	64	58	49	38	16	3

INSTRUCTIONS. — Using the uncorrected Snellen vision in the right eye, find the appropriate vertical column and come down to the horizontal line which corresponds to the uncorrected vision in the left eye. Where these columns meet, this number is the uncorrected BVE %. Then repeat the process using the corrected vision acuity to obtain the corrected BVE %. These two numbers are then used to determine if the applicant meets the visual acuity requirements for a specific program.

Table 2. Officer Training and Procurement Programs

Program	Visual Acuity Standard	Program	Visual Acuity Standard
A. NAVY PROGRAMS:			
1. Naval Academy	100% BVE uncorrected. ¹	16. Direct Appointment, USNR—MC, DC, MSC, and Male NC (draft liable); Female NC, and Intern Program.	Any degree correctable to at least 20/30 in the better eye.
2. Naval Academy Prep. School.	Do. ¹		
3. Project BOOST	Do. ¹	17. Appointment to Warrant Officer:	
4. NROTC, Scholarship . . .	Do. ¹	a. Deck, Operations & Ordnance Designators.	Any degree correctable to 100% BVE.
5. NROTC, College	Any degree correctable to 100% BVE.	b. All Other W.O. Designators.	Any degree correctable to 82% BVE.
6. NROTC, Scholarship from College.	100% BVE uncorrected. ¹	18. Direct Appointment, Merchant Marine Officer.	Any degree correctable to 100% BVE.
7. NESEP	Any degree correctable to 100% BVE.		
8. OCS—URL	Do.	B. MARINE CORPS PROGRAMS:	
OCS—RL & SC	Any degree correctable to 82% BVE.	1. PLC (ground) NROTC.	49% BVE correctable to 100% BVE. ²
9. NEDEP	Do.	2. OCC, ECP, PLC (Law), PLC (Graduate Students and All Other Direct Entry Programs (male)), NESEP.	20% BVE correctable to 100% BVE. ²
10. Merchant Marine Academy.	20/100 each eye both correctable to 20/20.	3. Commissioning—USMC & USMCR (male).	Do. ²
11. Augmentation—URL . . .	Any degree correctable to 100% BVE.	4. Direct Appointment, All Programs (female).	Any degree correctable to 76% BVE. ²
RL & SC	Any degree correctable to 82% BVE.	5. Appointment to Warrant Officer.	20% BVE correctable to 100% BVE. ²
12. JAG, MSC, CHC (19xx) . .	Do.		
13. MC, DC, NC (19xx) . . .	Do.		
14. Commissioning:			
a. USN & USNR—URL	Any degree correctable to 100% BVE.		
b. USN & USNR—RL & SC.	Any degree correctable to 82% BVE.		
15. Direct Appointment, USN—MC, DC, and Intern Program.	Any degree correctable to 82% BVE.		

¹Waivers may be recommended for exceptionally well—qualified applicants having any degree of visual acuity correctable to 100% BVE within the refractive error limits of table 3 below. Any condition which in the opinion of a qualified ophthalmologist may lead to progressive deterioration of eyesight or which requires the use of contact lenses to attain 100% BVE is disqualifying.

²Waivers may be recommended for exceptionally well—qualified applicants having uncorrected BVE not less than 3% and must be correctable to 100% BVE.

Table 3. Refractive Error Limits
(In any meridian)**COLLEGE TRAINING:**

URL $\pm 5.5D$.
 RL—SC $\pm 5.5D$.
 USMC $\pm 5.5D$.
 USMMA $\pm 3.25D$.

COMMISSION:

URL $\pm 5.5D$.
 RL—SC $\pm 8.0D$.
 USMC $\pm 5.5D$.
 (Waiver may be recommended to $\pm 8.0D$.)

In addition to the above limitations, the difference in the refractive errors in any meridian of the two eyes (anisometropia) may not exceed 3.5D. Cylinder correction may not exceed $\pm 3.0D$.

Note: Refractive error in any meridian.—When the signs of the sphere and cylinder (+ or -) are alike, the refractive error in any meridian is the algebraic sum of the two values. When the signs are not alike, the refractive error in any meridian is the higher absolute value of the two (usually the sphere).

15-15. Color Vision

(1) Color vision tests shall be administered and recorded on all applicants. Applicants for programs other than those listed in subarticle 15-15(2) shall be qualified regardless of color vision defects. Color vision tests shall be administered to these personnel, however, for record purposes.

(2) The following personnel categories or programs require that the Farnsworth Lantern Test be passed in order to qualify:

(a) Applicants for appointment as commissioned officers in the unrestricted line of the Navy or Naval Reserve.

(b) Applicants for the Naval Academy.

(c) Applicants for Regular NROTC, except selectees for an appointment in the Marine Corps.

(d) Applicants for appointment as limited duty officers with designators of 611x/621x, 612x/622x, 616x/626x, or 648x.

(e) Applicants for appointment as warrant officers with designators of 711x/721x, 712x/722x, 717x/727x, or 748x.

(f) Applicants for other officer candidate training programs that train candidates for appointments in the unrestricted line of the Navy or Naval Reserve.

(g) Applicants for training in naval aviation, diving, submarines, surface ship nuclear power, or other specialized schools that are listed in other sections of this chapter.

15-16. Genitourinary System

(1) *Methods of Examination.*—Evidence of venereal disease or malformation shall be searched for. The glands penis and corona shall be exposed and the penis stripped in the male. Both sides of the scrotum and the inguinal glands shall be palpated. In the female, complete inspection and palpation of the urinary meatus, vaginal mucosa, and palpation of the inguinal glands shall be performed. When possible, a complete pelvic examination with inspection and bimanual palpation of the cervix, corpus uteri, and adnexae shall also be performed. Routine urinalysis to determine the absence or presence of albumin and sugar shall be done on all examinees, the urine being voided in the presence of one of the examiners. Microscopic study of the urine shall be done when indicated.

(a) *Procedure When Albumin or Casts Are Found.*—When albumin, casts, hemoglobin, or red blood cells are found in the urine, the applicant shall not be accepted unless further study proves such findings to be of no significance. Such further study, if desired, should include 24 hour urine specimen for total protein. If urine contains between 30 and 150 mgs of albumin per 24 hours, the following tests are required: 12 hour recumbent urine for total protein (milligrams percent and total volume), urine culture,

creatinine clearance, microscopic examination of urine sediment, and an intravenous pyelogram, unless the presence of albumin and casts are associated with enlargement of the heart, high blood pressure, or other evidence of cardiovascular disease of such degree that a diagnosis of renal disease may be made immediately. When albumin is constantly or intermittently present, the underlying pathological condition should, if possible, be determined and stated as the cause for rejection.

(b) *Procedure When Glycosuria Is Detected.*—

If glucose is found in the urine, further specimens voided in the presence of the physician or authorized assistant should be examined. In doubtful situations, the employment of appropriate laboratory tests to demonstrate the possible existence of diabetes shall be made. (See art. 15-105.) If applicant is to be found qualified, the glycosuria must be shown to have been transient and not a persistent condition.

(2) *Genitalia.*—The following are causes for rejection (also see art. 15-16(3)).

(a) Bartholinitis, Bartholin's cyst.

(b) Cervicitis, acute or chronic, manifested by leukorrhea.

(c) Dysmenorrhea, incapacitating to a degree which necessitates recurrent absences of more than a few hours from routine activities.

(d) Endometriosis, or confirmed history thereof.

(e) Hermaphroditism.

(f) Hydrocele, if large or painful.

(g) Menopausal syndrome, either physiologic or artificial if manifested by more than mild constitutional or mental symptoms, or artificial menopause if less than 13 months have elapsed since cessation of menses. In all instances of artificial menopause, the clinical diagnosis will be reported; if accomplished by surgery, the pathologic report will be obtained and recorded.

(h) Menstrual cycle, irregularities of, including menorrhagia, if excessive; metrorrhagia; polymenorrhea; amenorrhea, except as noted above.

(i) New growths of the internal or external genitalia except single uterine fibroid, subserous, asymptomatic, less than 3 centimeters in diameter, with no general enlargement of the uterus.

(j) Oophoritis, acute or chronic.

(k) Ovarian cysts, persistent and considered to be of clinical significance.

(l) Pregnancy.

(m) Salpingitis, acute or chronic.

(n) Testicle(s):

(1) Absence or nondescent of both testicles.

(2) Undiagnosed enlargement or mass of testicle or epididymis.

(3) Undescended testicle which lies within the abdomen or inguinal canal.

- (o) Urethritis, acute or chronic.
 - (p) Uterus:
 - (1) Cervical polyps, cervical ulcer, or marked erosion.
 - (2) Endocervicitis, more than mild.
 - (3) Generalized enlargement of the uterus due to any cause.
 - (4) Malposition of the uterus if more than mildly symptomatic.
 - (q) Vagina:
 - (1) Congenital abnormalities or severe lacerations of the vagina.
 - (2) Vaginitis, acute or chronic, manifested by leukorrhea.
 - (r) Varicocele, if large or painful.
 - (s) Vulva:
 - (1) Leukoplakia.
 - (2) Vulvitis, acute or chronic.
 - (t) Major abnormalities and defects of the genitalia such as a change of sex, a history thereof, or complications (adhesions, disfiguring scars, etc.) residual to surgical correction of these conditions.
- (3) *Urinary System.*—The following are causes for rejection (also see art. 15-16(2)):
- (a) Albuminuria if persistent or recurrent. If the individual has some residual proteinuria under normal activity that does not exceed 150mg/24 hours, the individual should be accepted if there is no protein (less than 30 mg) in the urine specimen collected following 12 hours of recumbency and if the other examinations required by art. 15-16(1)(a) are normal.
 - (b) Cystitis, chronic. Individuals with acute cystitis are unacceptable until the condition is cured.
 - (c) Enuresis determined to be a symptom of an organic defect (also see art. 15-23(4)(c)(2)).
 - (d) Congenital malformation of the penis:
 - (1) Epispadias.
 - (2) Hypospadias, when accompanied by evidence of infection of urinary tract or if unable to void normally.
 - (e) Hematuria, pyuria, cylindruria, or other findings indicative of renal tract disease.
 - (f) Incontinence of urine.
 - (g) Kidney:
 - (1) Absence of one kidney, regardless of cause.
 - (2) Acute or chronic infections of the kidney.
 - (3) Cystic or polycystic kidney, confirmed history of.
 - (4) Hydronephrosis or pyonephrosis.
 - (5) Nephritis, acute or chronic.
 - (6) Pyelitis, pyelonephritis.
 - (h) Penis, amputation of, if the resulting stump is insufficient to permit micturition in a normal manner.
 - (i) Prostate gland, hypertrophy of, with urinary retention.

- (j) Renal calculus:
 - (1) Substantiated history of bilateral renal calculus at any time.
 - (2) Verified history of renal calculus at any time with evidence of stone formation within the preceding 12 months, current symptoms or positive X-ray for calculus.
- (k) Skeneitis.
- (l) Urethra:
 - (1) Stricture of the urethra.
 - (2) Urethritis, acute or chronic.
- (m) Urinary fistula.
- (n) Other diseases and defects of the urinary system which obviously preclude satisfactory performance of duty or which would require frequent and prolonged treatment.

15-17. Head and Neck

- (1) *General.*—The head shall be carefully inspected, and palpated for evidence of injury, deformity, and tumor growth. The cause of scars and deformity should be inquired into. The examination of the neck shall include careful inspection and palpation for glandular enlargement, deformity, crepitus, limitation of motion, and asymmetry. If either the head or neck is grossly enlarged, the circumference may be measured and the figure recorded.
- (2) *Head.*—The following are causes for rejection:
 - (a) Abnormalities which are apparently temporary in character resulting from recent injuries until a period of 3 months has elapsed. These include severe contusions and other wounds of the scalp and cerebral concussion.
 - (b) Deformities of the skull in the nature of depressions, exostoses, etc., of a degree which would prevent the individual from wearing a gas mask or military headgear, or which affect the military appearance of the candidate.
 - (c) Deformities of the skull of any degree associated with evidence of disease of the brain, spinal cord, or peripheral nerves.
 - (d) Depressed fractures near central sulcus with or without convulsive seizures.
 - (e) Loss or congenital absence of the bony subsistence of the skull which has not been corrected by reconstructive material:
 - (1) All instances involving absence of the bony substance of the skull which have been corrected, but in which the defect is in excess of 1 square inch (6.45 cm²) or the size of a 25 cent piece, shall be referred to BUMED together with a report of consultation.
 - (2) The report of consultation shall include an evaluation of any evidence of alteration of brain function in any of its several spheres; i.e., intelligence, judgment, perception, behavior, motor control, and sensory function, as well as any evidence of active bone disease or other related complications.

Current X-rays and other pertinent laboratory data shall accompany such a report of consultation.

(f) Unsightly deformities, such as large birthmarks, large hairy moles, extensive scars, and mutilations due to injuries or surgical operations; ulcerations; fistulae, atrophy, or paralysis of part of the face or head.

(3) *Neck.*—The following are causes for rejection:

(a) Cervical ribs if symptomatic or so obvious that they are found on routine physical examination. (Detection based primarily on X-ray is not considered to meet this criterion.)

(b) Congenital cysts of branchial cleft origin or those developing from the remnants of the thyroglossal duct, with or without fistulous tracts.

(c) Fistula, chronic draining, of any type.

(d) History of tuberculous lymphadenitis that has not been treated with at least 2 years of dual drug antituberculous therapy.

(e) Nonspastic contraction of the muscles of the neck or cicatricial contracture of the neck to the extent that it interferes with the wearing of a uniform or military equipment or so disfiguring as to make the individual objectionable in common social relationships.

(f) Spastic contraction of the muscles of the neck, persistent, and chronic.

(g) Tumor of thyroid or other structures of the neck. (See art. 15-27(1)(b)(5).)

15-18. Heart and Vascular System

(1) For methods of examination refer to article 15-98.

(2) The following are causes for rejection:

(a) All organic valvular diseases of the heart, including those improved by surgical procedures.

(b) Coronary artery disease or myocardial infarction, old or recent or true angina pectoris, at any time.

(c) Electrocardiographic evidence of major arrhythmias such as:

(1) Atrial tachycardia, flutter, or fibrillation, ventricular tachycardia or fibrillation.

(2) Conduction defects such as first degree atrio-ventricular block, right bundle branch block, and second degree AV block of the Wenckebach variety. (These conditions occurring as isolated findings are not unfitting when cardiac evaluation reveals no cardiac disease.)

(3) Left bundle branch block, other 2nd and 3rd degree AV block.

(4) Unequivocal electrocardiographic evidence of old or recent myocardial infarction; coronary insufficiency at rest or after stress; or evidence of heart muscle disease.

(d) Hypertrophy or dilation of the heart as evidenced by clinical examination or roentgenographic examination and supported by electrocardio-

graphic examination. Care should be taken to distinguish abnormal enlargement from increased diastolic filling as seen in the well conditioned subject with a sinus bradycardia. Instances of enlarged heart by X-ray not supported by electrocardiographic examination will be forwarded to BUMED for evaluation.

(e) Myocardial insufficiency (congestive circulatory failure, cardiac decompensation) obvious or covert, regardless of cause.

(f) Paroxysmal tachycardia within the preceding 5 years, or any time if recurrent or disabling or if associated with electrocardiographic evidence of accelerated A-V conduction (Wolff-Parkinson-White).

(g) Pericarditis, endocarditis, or myocarditis, history or finding of, except for a history of a single acute idiopathic pericarditis or coxsackie with no residuals.

(h) Tachycardia, persistent with a resting pulse rate of 100 or more, regardless of cause.

(i) Congenital or acquired lesions of the aorta and major vessels, such as syphilitic aortitis, demonstrable atherosclerosis which interferes with circulation, congenital or acquired dilatation of the aorta (especially if associated with other features of Marfan's syndrome), and pronounced dilatation of the main pulmonary artery.

(j) Hypertension evidenced by predominant blood pressure readings of 150 mm or more systolic in an individual over 35 years of age or preponderant readings of 140 mm or more systolic in an individual 35 years of age or less. Preponderant diastolic pressure over 90 mm diastolic is cause for rejection at any age.

(k) Marked circulatory instability as indicated by orthostatic hypotension, persistent tachycardia, severe peripheral vasomotor disturbances and sympatheticotonia.

(l) Peripheral vascular disease including Raynaud's phenomena, Buerger's disease (thromboangiitis obliterans), erythromelalgia, arteriosclerotic and vascular diseases. Special tests will be employed in doubtful situations.

(m) Thrombophlebitis:

(1) History of thrombophlebitis with persistent thrombus or evidence of circulatory obstruction of deep venous incompetence in the involved veins.

(2) Recurrent thrombophlebitis.

(n) Varicose veins, if more than mild, or if associated with edema, skin ulceration, or residual scars from ulceration.

(o) Aneurysm of the heart or major vessel, congenital or acquired.

(p) History and evidence of a congenital abnormality which has been treated by surgery but with residual abnormalities or complications, for example: Patent ductus arteriosus with residual

cardiac enlargement or pulmonary hypertension; resection of a coarctation of the aorta without a graft when there are other cardiac abnormalities or complications; closure of a secundum type atrial septal defect when there are residual abnormalities or complications.

(q) Major congenital abnormalities and defects of the heart and vessels unless satisfactorily corrected without residuals or complications. Uncomplicated dextrocardia and other minor asymptomatic anomalies are acceptable.

(r) Substantiated history of rheumatic fever or chorea within the previous 2 years, recurrent attacks of rheumatic fever or chorea at any time, or with evidence of residual cardiac damage.

15-19. Height, Weight, and Body Build

(1) *Height*.—The applicant's height shall be measured in inches to the nearest one-half inch (1.27 cm) (aviation to the nearest tenth of an inch (0.25 cm), art. 15-70(4)(a)(3)), without shoes, by a measuring scale known to be accurate. Height shall be recorded in inches (with centimeters shown in parentheses). To convert to centimeters multiply inches by 2.54. The table below sets forth the minimum and maximum heights acceptable for the several categories of naval service.

Minimum and maximum standards of height

Category	Minimum		Maximum
	in.	cm	
1. Officer Training Programs:			
a. Unrestricted Line Input	62	(157.48)	•
b. Restricted Line & Staff Corps Input	60	(152.40)	•
c. Marine Corps, All Programs	66	(167.64)	•
2. Appointment; USN & USNR:			
a. Unrestricted Line	62	(157.48)	•
b. Restricted Line & Staff Corps	60	(152.40)	•
c. Warrant Officer & Limited Duty Officer:			
(1) Deck, Operations & Ordnance Designators . .	62	(157.48)	•
(2) All Other Designators . .	60	(152.40)	•
3. Appointment, USMC, USMCR:			
a. All Categories, Including WO	66	(167.64)	•
4. Navy and Marine Corps, Females:			
a. All Categories	60	(152.40)	•

*Maximum height for all categories is 78 inches (198.12 cm).

(2) *Weight*.—The applicant shall be weighed, in undergarments only, on a standard set of scales which is known to be correct. The weight shall be recorded in pounds (with kilograms shown in parentheses). Fractions of pounds shall not be recorded. To convert to kilograms, multiply pounds by 0.45. The applicant's weight should be well distributed and in proportion to age, sex, and skeletal structure. The following tables (1, 2, and 3) set forth the suggested minimum and maximum weight limits as related to age and height. The tables are provided as a guide to medical examiners and should not be construed too strictly. For example, an individual may fall between the extremes of the minimum and maximum and be not qualified because of marked variations in physical proportions. An applicant, however, whose weight falls at the extremes of either the minimum or maximum range is acceptable only if applicant is obviously active, of firm musculature, and evidently vigorous and healthy. When doubt exists as to proper proportionment, photographs taken in appropriate attire (such as bathing suit) to show trunk and limb development should be forwarded with the physical examination report to the Bureau for consideration; this applies also to individuals above the maximum weight who present proper proportionment and are evidently vigorous and healthy.

(3) *Body Build*.—A thorough, general inspection of the entire body shall be made, noting the proportion and symmetry of the various parts of the body, the chest development, the condition and tone of the muscles, and general nutrition. The build shall be recorded as slender, medium, heavy, or obese. The following are causes for rejection:

(a) Congenital malformation of bones and joints.

(b) Deficient muscular development which would interfere with the completion of required training.

(c) Evidences of congenital asthenia (slender bones; weak thorax; visceroptosis; severe, chronic constipation; or "drop heart" if marked in degree).

(d) Obesity. Even though the individual's weight is within the maximum shown in article 15-19(2) (tables 1, 2, and 3), the individual shall be reported as not physically qualified when the examining physician considers that the weight in relation to the body structure and musculature constitutes obesity of such a degree as to interfere with the satisfactory completion of required training.

Table 1. Weight standards for male officers and officer candidates Navy and Marine Corps, except aviation personnel

Weight according to age and height						
Height inches (cm)	Minimum (regardless of age)	Maximum (Weight in parentheses is kilograms)				
		16-20 years	21-30 years	31-35 years	36-40 years	41 years and over
58 (147.32)	98 (44.10)	147 (66.15)	153 (68.85)	151 (67.95)	147 (66.15)	140 (63.00)
59 (149.86)	99 (44.55)	152 (68.40)	157 (70.65)	156 (70.20)	152 (68.40)	145 (65.25)
60 (152.40)	100 (45.00)	158 (71.10)	163 (73.35)	162 (72.90)	157 (70.65)	150 (67.50)
61 (154.94)	102 (45.90)	163 (73.35)	168 (75.60)	167 (75.15)	162 (72.90)	155 (69.75)
62 (157.48)	103 (46.35)	168 (75.60)	174 (78.30)	173 (77.85)	168 (75.60)	160 (72.00)
63 (160.02)	104 (46.80)	174 (78.30)	180 (81.00)	178 (80.10)	173 (77.85)	165 (74.25)
64 (162.56)	105 (47.25)	179 (80.55)	185 (83.25)	184 (82.80)	179 (80.55)	171 (76.95)
65 (165.10)	106 (47.70)	185 (83.25)	191 (85.95)	190 (85.50)	184 (82.80)	176 (79.20)
66 (167.64)	107 (48.15)	191 (85.95)	197 (88.65)	196 (88.20)	190 (85.50)	182 (81.90)
67 (170.18)	111 (49.95)	197 (88.65)	203 (91.35)	202 (90.90)	196 (88.20)	187 (84.15)
68 (172.72)	115 (51.75)	203 (91.35)	209 (94.05)	208 (93.60)	202 (90.90)	193 (86.85)
69 (175.26)	119 (53.55)	209 (94.05)	215 (96.75)	214 (96.30)	208 (93.60)	198 (89.10)
70 (177.80)	123 (55.35)	215 (96.75)	222 (99.90)	220 (99.00)	214 (96.30)	204 (91.80)
71 (180.34)	127 (57.15)	221 (99.45)	228 (102.60)	227 (102.15)	220 (99.00)	210 (94.50)
72 (182.88)	131 (58.95)	227 (102.15)	234 (105.30)	233 (104.85)	226 (101.70)	216 (97.20)
73 (185.42)	135 (60.75)	233 (104.85)	241 (108.45)	240 (108.00)	233 (104.85)	222 (99.90)
74 (187.96)	139 (62.55)	240 (108.00)	248 (111.60)	246 (110.70)	239 (107.55)	228 (102.60)
75 (190.50)	143 (64.35)	246 (110.70)	254 (114.30)	253 (113.85)	246 (110.70)	234 (105.30)
76 (193.04)	147 (66.15)	253 (113.85)	261 (117.45)	260 (117.00)	252 (113.40)	241 (108.45)
77 (195.58)	151 (67.95)	260 (117.00)	268 (120.60)	266 (119.70)	259 (116.55)	247 (111.15)
78 (198.12)	153 (68.85)	267 (120.15)	275 (123.75)	273 (122.85)	266 (119.70)	254 (114.30)
79 (200.66)	157 (70.65)	273 (122.85)	282 (126.90)	280 (126.00)	273 (122.85)	260 (117.00)

Note.—Height standards are contained in art. 15-19(1).

Table 2. Weight standards for Navy and Marine Corps aviation personnel, including aviation officer candidates

Height (inches) (Centimeters)	64 (162.56)	65 (165.10)	66 (167.64)	67 (170.18)	68 (172.72)	69 (175.26)	70 (177.80)	71 (180.34)	72 (182.88)	73 (185.42)	74 (187.96)	75 (190.50)	76 (193.04)	77 (195.58)	78 (198.12)
Weight															
Minimum (pounds)	105	106	107	111	115	119	123	127	131	135	139	143	147	151	153
(kilograms)	(47.25)	(47.70)	(48.15)	(49.95)	(51.75)	(53.55)	(55.35)	(57.15)	(58.95)	(60.75)	(62.55)	(64.35)	(66.15)	(67.95)	(68.85)
Maximum (pounds) . . .	160	165	170	175	181	186	192	197	203	209	214	219	225	230	235
(kilograms)	(72.00)	(74.25)	(76.50)	(78.75)	(81.45)	(83.70)	(86.40)	(88.65)	(91.35)	(94.05)	(96.30)	(98.55)	(101.25)	(103.50)	(105.75)

Table 3. Weight standards for all categories of women

Weight according to age and height							
Height in (cm)	Minimum (regardless of age)	Maximum (Weights in parentheses are kilograms)					
		17-20	21-24	25-30	31-35	36-40	41 years and over
58 (147.32)	90 (40.50)	121 (54.45)	123 (55.35)	124 (55.80)	126 (56.70)	135 (60.75)	135 (60.75)
59 (149.86)	92 (41.40)	123 (55.35)	125 (56.25)	129 (58.05)	129 (58.05)	139 (62.55)	138 (62.10)
60 (152.40)	94 (42.30)	125 (56.25)	127 (57.15)	132 (59.40)	132 (59.40)	142 (63.90)	141 (63.45)
61 (154.94)	96 (43.20)	127 (57.15)	129 (58.05)	135 (60.75)	136 (61.20)	145 (65.25)	147 (66.15)
62 (157.48)	98 (44.10)	130 (58.50)	132 (59.40)	139 (62.55)	141 (63.45)	148 (66.60)	147 (66.15)
63 (160.02)	100 (45.00)	134 (60.30)	137 (61.65)	141 (63.45)	145 (65.25)	151 (67.95)	150 (67.50)
64 (162.56)	102 (45.90)	138 (62.10)	141 (63.45)	145 (65.25)	150 (67.50)	156 (70.20)	154 (69.30)
65 (165.10)	104 (46.80)	142 (63.90)	145 (65.25)	149 (67.05)	155 (69.75)	161 (72.45)	159 (71.55)
66 (167.64)	106 (47.70)	147 (66.15)	150 (67.50)	154 (69.30)	160 (72.00)	165 (74.25)	164 (73.80)
67 (170.18)	109 (49.05)	151 (67.95)	155 (69.75)	159 (71.55)	165 (74.25)	171 (76.95)	169 (76.05)
68 (172.72)	112 (50.40)	156 (70.20)	159 (71.55)	163 (73.35)	169 (76.05)	176 (79.20)	174 (78.30)
69 (175.26)	115 (51.75)	160 (72.00)	164 (73.80)	168 (75.60)	175 (78.75)	181 (81.45)	179 (80.55)
70 (177.80)	118 (53.10)	165 (74.25)	169 (76.05)	173 (77.85)	180 (81.00)	186 (83.70)	184 (82.80)
71 (180.34)	122 (54.90)	170 (76.50)	174 (78.30)	178 (80.10)	185 (83.25)	192 (86.40)	190 (85.50)
72 (182.88)	125 (56.25)	175 (78.75)	178 (80.10)	183 (82.35)	190 (85.50)	197 (88.65)	195 (87.75)
73 (185.42)	128 (57.60)	180 (81.00)	183 (82.35)	188 (84.60)	195 (87.75)	202 (90.90)	200 (90.00)
74 (187.96)	132 (59.40)	184 (82.80)	189 (85.05)	193 (86.85)	201 (90.45)	208 (93.60)	206 (92.70)
75 (190.50)	136 (61.20)	189 (85.05)	194 (87.30)	199 (89.55)	206 (92.70)	214 (96.30)	212 (95.40)
76 (193.04)	139 (62.55)	195 (87.75)	199 (89.55)	204 (91.80)	212 (95.40)	219 (98.55)	217 (97.65)
77 (195.58)	143 (64.35)	200 (90.00)	204 (91.80)	209 (94.03)	217 (97.65)	225 (101.25)	223 (100.35)
78 (198.12)	147 (66.15)	205 (92.25)	209 (94.05)	215 (96.75)	223 (100.35)	231 (103.95)	229 (103.05)
79 (200.66)	151 (67.95)	209 (94.05)	213 (95.85)	219 (98.55)	227 (102.15)	234 (105.30)	231 (103.95)

15-20. Lungs and Chest Wall

(1) A history pertaining to past pulmonary diseases shall be obtained from the applicant; the chest shall be examined by inspection, palpation, percussion and auscultation; and finally a roentgenographic examination of the chest shall be made (see art. 15-101) as part of the examination to determine physical fitness for entry into the service.

(a) *History*.—The applicant shall be questioned regarding contact with tuberculosis. Familial tuberculosis may indicate a constitutional predisposition to the disease as well as opportunity for infection. Since pleurisy, with or without effusion, is a frequent indication of early tuberculosis, the greatest care should be taken in examining applicants who have apparently recovered from pleurisy. An occupational history of mining, sandblasting, or other enclosed exposure to dust should make the pneumoconioses suspect. A history of any of the following symptoms, especially when protracted, should give suspicion of significant pulmonary pathology: fever, malaise, night sweats, cough and expectoration, hemoptysis, wheezing, dyspnea, hoarseness, loss of appetite, loss of strength, loss of weight, or any decrease in activity tolerance.

(b) *Examination*.—The applicant should be seated in a comfortable relaxed position with direct light falling upon the chest. Careful comparison of the findings elicited over symmetrical areas on the two sides of the chest gives the most accurate information regarding the condition of the underlying structures.

(c) *Inspection*.—Observe for asymmetry of the thoracic cage; asymmetry, dimpling or nipple retraction of the breasts; abnormal pulsations; atrophy of the shoulder girdle or pectoral muscles; and limited or lagging expansion on forced inspiration. The large, rounded, relatively immobile "barrel" chest may be regarded as evidence of significant pulmonary emphysema.

(d) *Palpation*.—Observe for tumors of the breast or thoracic wall, enlarged cervical, supraclavicular, or axillary lymph nodes, deviation of the trachea in the suprasternal notch, and thrills associated with respiration or the cardiac cycle. Instruct the examinee to repeat such a word as "moon" or "ninety-nine" in a deep voice and palpate symmetrical areas over the two lungs for differences in the intensity of tactile fremitus.

(e) *Percussion*.—Light percussion should be used with the pleximeter finger held lightly against the chest parallel to the ribs. Thus slight changes in the percussion note are best felt and heard when symmetrical areas of the two lungs are percussed. Note mobility of the diaphragm by percussing the lung bases at forced inspiration and again at forced expiration.

(f) *Auscultation*.—Instruct applicant to breathe freely but not deeply through the mouth. Listen to an entire respiratory cycle before moving the stethoscope bell to another area. Note wheezing, rales, or friction rubs. Compare the pitch and intensity of breath sounds heard over symmetrical areas of the two lungs. Instruct applicant to whisper such words as "one—two—three." Note increase or decrease in intensity of whispered voice conduction over symmetrical areas of the two lungs. There is normally an increase in pitch and intensity of the breath sounds and whispered voice over the apex of the right lung as compared to the left because of the closer proximity of the trachea to the former. Instruct applicant to exhale, cough lightly, and immediately inhale. Auscultate the chest during this process. Note any rales, paying particular attention to moist rales that "break" with the cough or fine rales heard at the beginning of inspiration immediately after cough.

(g) *Functional Examination*.—

(1) A careful history of functional capacity under stress and exercise shall be taken. Any applicant presenting a history suggestive of chronic pulmonary disease or functional incapacity shall be carefully examined in that respect.

(2) The ability to ascend and descend a full flight of stairs is a rough test of functional capacity. The applicant will be observed during this exercise and any cyanosis, dyspnea, unusual respiratory distress, or other abnormal findings will be noted.

(3) Where airway obstruction is a question, the "match" test may be used. The applicant is asked to blow out a half-burned match, held 6 inches from the mouth (fully open). The applicant is asked to take a full breath and blow out the match with a single, maximal expiration (mouth wide open, lips not pursed). Individuals unable to extinguish the match should be considered to have a significant degree of airway obstruction.

(2) *General*.—The following are causes for rejection:

(a) Abnormal elevation of the diaphragm on either side.

(b) Acute abscess of the lung.

(c) Acute bronchitis until the condition is cured.

(d) Acute fibrinous pleurisy, associated with acute nontuberculous pulmonary infection.

(e) Acute mycotic disease of the lung such as coccidioidomycosis and histoplasmosis.

(f) Acute nontuberculous pneumonia.

(g) Foreign body in trachea or bronchus.

(h) Foreign body in the chest wall causing symptoms.

(i) Lobectomy, history of, for a nontuberculous, nonmalignant lesion with residual pulmonary disease. Removal of more than one lobe is cause for rejection regardless of the absence of residuals.

(j) Other traumatic lesions of the chest and its contents.

(k) Pneumothorax or history thereof within 1 year of date of examination if due to simple trauma or surgery; within 3 years of date of examination if of spontaneous origin. Surgical correction is acceptable if no significant residual disease or deformity remains and pulmonary function tests are within normal limits.

(l) Significant abnormal findings on physical examination of the chest.

(m) Significant pulmonary functional incapacity.

(3) *Tuberculous Lesions.*—The following are causes for rejection (see also art. 15-26):

(a) Active tuberculosis in any form or location.

(b) Pulmonary tuberculosis, active within the past 5 years.

(c) Substantiated history or X-ray findings of pulmonary tuberculosis of more than minimal extent at any time; or minimal tuberculosis not treated with at least 24 months of approved chemotherapy consisting of at least two antituberculous drugs or combined chemotherapy and surgery (surgery at least 1 year prior to discontinuation of therapy and the antituberculous chemotherapy being no less than 24 months duration and utilizing at least two antituberculous drugs).

(4) *Nontuberculous Lesions.*—The following are causes for rejection:

(a) Acute mastitis, chronic mastitis, if more than mild.

(b) Bronchial asthma or recurrent asthmatic bronchitis since 12th birthday.

(c) Bronchitis, chronic, with evidence of pulmonary function disturbance.

(d) Bronchiectasis.

(e) Bronchopleural fistula.

(f) Bullous or generalized pulmonary emphysema.

(g) Chronic abscess of lung.

(h) Chronic fibrous pleural adhesions of sufficient extent to interfere with pulmonary function or obscure the lung field in the roentgenogram.

(i) Chronic mycotic diseases of the lung including coccidioidomycosis; residual cavitation or more than a few small sized inactive and stable residual nodules demonstrated to be due to mycotic disease.

(j) Congenital malformations or acquired deformities which result in reducing the chest capacity and diminishing the cardiac or respiratory functions to such degree as to interfere with vigorous physical exertion, or that produce disfigurement when the applicant is dressed.

(k) Empyema, residual sacculation or unhealed sinuses of chest wall following operation for empyema.

(l) Extensive pulmonary fibrosis from any cause.

(m) Foreign body in the lung or mediastinum causing symptoms or active inflammatory reaction.

(n) Multiple cystic disease of the lung or solitary cyst which is large and incapacitating.

(o) New growth of breast.

(p) Osteomyelitis of rib, sternum, clavicle, scapula, or vertebra.

(q) Pleurisy with effusion of unknown origin within the previous 2 years.

(r) Sarcoidosis. (See 15-26.)

(s) Suppurative periostitis of rib, sternum, clavicle, scapula, or vertebra.

15-21. Mouth, Nose, Pharynx, Trachea, Esophagus, and Larynx

(1) *General.*—A complete examination by reflected light shall be made of the anterior and posterior nares, the nasopharynx and pharynx, and when necessary, the larynx. When considered necessary, transillumination and X-ray shall be employed.

(2) *The Mouth.*—The following are causes for rejection:

(a) Hard palate, perforation of.

(b) Harelip, unless satisfactorily repaired by surgery.

(c) Leukoplakia, if severe.

(d) Lips, unsightly mutilations of, from wounds, burns, or disease.

(e) Ranula, if extensive. For other tumors, see also article 15-27.

(3) *Nose.*—The following are causes for rejection:

(a) Allergic manifestations.

(1) Chronic atrophic rhinitis.

(2) Hay fever, if severe.

(b) Choana, atresia, or stenosis of, if symptomatic.

(c) Nasal septum, perforation of:

(1) Associated with interference of function, ulceration or crusting, and when the result of organic disease.

(2) If progressive.

(3) If respiration is accompanied by whistling sound.

(d) Sinusitis, acute.

(e) Sinusitis, chronic:

(1) Evidenced by chronic purulent nasal discharge, large nasal polyps, hyperplastic changes of the nasal tissues and other signs and symptoms.

(2) Confirmed by transillumination or X-ray examination or both.

(4) *Pharynx, Trachea, Esophagus, and Larynx.*—The following are causes for rejection:

(a) Dysphonia due to plica ventricularis.

(b) Esophagus, organic diseases of, such as ulceration, varices, achalasia, peptic esophagitis, if

confirmed by appropriate X-ray or esophagoscopic examinations.

(c) Laryngeal paralysis, sensory or motor, due to any cause.

(d) Larynx, organic disease of, such as neoplasm, polyps, granuloma, ulceration, and chronic laryngitis.

(e) Tracheostomy or, tracheal fistula.

(5) *Other Defects and Diseases.* — The following are causes for rejection:

(a) Aphonia.

(b) Deformities or conditions of the mouth, throat, pharynx, larynx, esophagus, and nose which interfere with mastication and swallowing of ordinary food, with speech, or with breathing.

(c) Destructive syphilitic disease of the mouth, nose, throat, larynx, or esophagus.

(d) Pharyngitis and nasopharyngitis, chronic, with positive history and objective evidence, if of such a degree as to result in excessive time lost in the military environment.

15-22. Neurological Disorders

(1) The neurological examination shall be conducted as follows: The individual shall walk a straight line at a brisk pace with eyes open, stop, and turn around. The individual shall then return in the same manner with eyes closed, stop, and turn around. Look for spastic, ataxic, incoordinate, or limping gait; absence of normal associated movements; deviation to one side or the other; the presence of abnormal involuntary movements; undue difference in performance with the eyes open and closed. The individual shall then stand erect, feet together, arms extended in front. Look for unsteadiness and swaying, deviation of one or both of the arms from the assumed position, tremors, or other involuntary movements. With eyes closed, the candidate shall then touch his/her nose with the right and then the left index finger. Look for ataxia, tremors, overshooting, particularly at the end of the movement. Examine joint and spine movements and muscle condition. Look for muscle atrophy or pseudohypertrophy, muscular weakness, limitation of joint movement, and spine stiffness. As to pupils, look for irregularity, inequality, diminished or absent contraction to light, movements of eyes, facial muscles, and tongue. Look for strabismus, ptosis, sustained nystagmus, tremors of retracted lips, asymmetry or tremors of face or tongue. Sensation shall be examined by pricking lightly each side of the forehead, bridge of nose, and chin, across the volar surface of each wrist, and dorsum of each foot. Look for inequality of sensation right and left. If these sensations are abnormal, vibration sense should be tested at ankles and wrists by tuning fork. With eyes closed, the candidate shall move each heel down the other

leg from knee to ankle. Test sense of movement of great toes and thumb. Look for diminution or loss of vibration and sense of position, and ataxia. Knee jerks and plantar reflexes should be tested. When indicated, appropriate laboratory tests and X-ray examinations shall be made.

(2) The following are causes for rejection:

(a) Degenerative disorders:

(1) Cerebellar and Friedreich's ataxia.

(2) Cerebral arteriosclerosis.

(3) Encephalomyelitis, residuals of, which preclude the satisfactory performance of military duty.

(4) Huntington's chorea.

(5) Multiple sclerosis.

(6) Muscular atrophies and dystrophies of any type.

(b) Miscellaneous:

(1) Congenital malformations if associated with neurological manifestations and meningocele even if uncomplicated.

(2) History of chronic motion sickness.

(3) Migraine, when frequent and incapacitating.

(4) Paralysis or weakness, deformity, discoordination, pain, sensory disturbance, intellectual deficit, disturbance of consciousness, or personality abnormality regardless of cause which is of such a nature or degree as to preclude the satisfactory performance of military duty.

(5) Tremors, spasmodic torticollis, athetosis, or other abnormal movements more than mild.

(c) Neurosyphilis of any form (general paresis, tabes dorsalis, meningovascular syphilis).

(d) Paroxysmal convulsive disorders, disturbances of consciousness, all forms of psychomotor or temporal lobe epilepsy or history thereof except under the following circumstances:

(1) No seizure since age 5.

(2) Individuals who have had seizures since age 5 but who, during the 5 years immediately preceding examination for military service, have been totally seizure free and have not been taking any type of anticonvulsant medication for the entire period will be considered on an individual basis. Documentation in these cases must be from attending or consulting physician and the original electroencephalogram tracing (not a copy) taken within the preceding 3 months must be submitted for evaluation by COMNAVMECDOM.

(e) Peripheral nerve disorder:

(1) Polyneuritis.

(2) Mononeuritis or neuralgia which is chronic or recurrent and of an intensity that is periodically incapacitating.

(3) Neurofibromatosis.

(f) Spontaneous subarachnoid hemorrhage, verified history of, unless cause has been surgically corrected.

15—23. Psychoses, Psychoneuroses, and Personality Disorders

(1) *Examination Technic.*—

(a) The diagnosis of most psychiatric disorders depends upon an adequate longitudinal history. When necessary, this information should be corroborated by supplemental information from family, family physician, schools, churches, hospitals, social service or welfare agencies, and courts.

(b) Mental and personality difficulties are most clearly revealed in the candidate's behavior toward those with whom the candidate feels relatively at ease. The most successful approach is one of straightforward professional inquiry, coupled with real respect for the individual's personality and due consideration for the candidate's feelings.

(c) The psychiatric examination should be conducted out of hearing of other persons. Significant historical information might be withheld when the individual feels that the responses must be impersonal and gives replies that will not impress listeners with his/her peculiarity. The examiner should pay close attention to the content and implication of everything said and to any other clues, and, in a matter—of—fact manner, followup whatever is not self—evident or within acceptable limits of normal.

(d) The Standard Form 93 shall be carefully reviewed before the candidate is examined by the medical officer. If any of the last 5 items in question 11 are checked "yes", the examiner should be alerted to possible psychiatric difficulties in the candidate. There are, in addition, other items which could possibly indicate emotional difficulties. For example, "yes" answers to several of the following might be indicative of anxiety, depression, or frustration in interpersonal relationships: dizziness or fainting spells, shortness of breath, palpitation or pounding heart, bed wetting since age 12, attempted suicide, been a sleepwalker, or stutters or stammers habitually.

(e) In an attempt to predict how an individual will adjust in the future, a review of past adjustment is the most accurate guideline on which to base an opinion. Therefore, the candidate's occupational, school, and previous (if any) military records should be thoroughly investigated. The candidate's ability to adhere to the expected social mores is further evidence of emotional stability; therefore, civilian disciplinary records shall be carefully evaluated.

(f) To evaluate the applicant's ability to adjust to the demands of military service, it is desirable to estimate the capacity for duty under the following conditions: (1) separation from home and family; (2) restricted environment aboard ship; (3) necessity for obedience to military discipline; (4) lack of privacy; (5) extremes of climate; (6) exhaustion; and (7) the possibility of bodily injury.

(g) It is fully appreciated that a candidate's motivation for service cannot always be determined. In fact, the candidate's motivation may be

sincere, under the less stressful demands of service, only to become unmotivated during periods of rigorous training or arduous duty, with a demonstration of the applicant's basic psychopathology.

(h) The examiner, during the course of a routine physical examination of the candidate, has ample opportunity to be aware of the following: (1) inability to understand and execute requests promptly and adequately; (2) lack of normal response; (3) abnormal anxiety; (4) silly inappropriate laughter; (5) abnormal seclusiveness; (6) over displays of hostility or stubbornness; (7) retarded psychomotor activity; (8) abnormal shyness; (9) paranoid tendencies; (10) obviously below normal I.Q.; (11) a history of enuresis or sleepwalking persisting into late childhood or adolescence (see also art. 15—23(4)(c)); and (12) abnormal autonomic nervous system responses; i.e., giddiness, fainting, blushing, excessive sweating. Note also the lack of such normal anxiety or autonomic responses as might reasonably be expected under circumstances of examination and other processing.

(i) The psychiatric member of the formal physical examination board for the U.S. Naval Academy and the ROTC Four-Year Scholarship Program shall administer the below Reading Aloud Test to each candidate. For other officer candidates, the test shall be administered by a psychiatrist (if available), or the medical examiner, if there is evidence or history of speech impediment of any degree. The test shall be administered as follows: (1) have the candidate stand erect, face the medical examiner across the room and read aloud, as if confronting a class of students; (2) if the candidate pauses, even momentarily, on any phrase or word the medical examiner immediately and sharply says, "What's that?", and requires the examinee to start over again with the first sentence of the test; (3) on the second trial, the true stammerer usually will halt again at the same word or phonetic combination and will often reveal serious stammering.

Reading Aloud Test

You wished to know all about my grandfather. Well, he is nearly 93 years old; he dresses himself in an ancient black frock—coat, usually minus several buttons; yet he still thinks as swiftly as ever. A long, flowing beard clings to his chin, giving those who observe him a pronounced feeling of the utmost respect. When he speaks, his voice is just a bit cracked and quivers a trifle. Twice each day he plays skillfully and with zest upon our small organ. Except in winter when the ooze or snow or ice is present, he slowly takes a short walk in the open air each day. We have often urged him to walk more and smoke less, but he always answers, "Banana Oil." Grandfather likes to be modern in his language.

(2) *Psychoses.*—The following are causes for rejection:

(a) Psychosis.

(b) Authenticated history of psychotic illness other than of a brief duration associated with a toxic or infectious process.

(3) *Psychoneuroses*.—The following are causes for rejection:

(a) History of psychoneurotic reaction which caused:

- (1) Hospitalization.
- (2) Prolonged care by a physician.
- (3) Loss of time from normal pursuits for repeated periods even if of brief duration, or—
- (4) Symptoms or behavior of a repeated nature which impaired school or work efficiency.

(b) History of a brief psychoneurotic reaction or nervous disturbance within the preceding 12 months which was sufficiently severe to require medical attention or absence from work or school for a brief period.

(4) *Personality Disorders*.—The following are causes for rejection:

(a) Personality disorders or mental retardation as listed in International Classification of Diseases, current edition.

(1) Frequent encounters with law enforcement agencies, or antisocial attitudes or behavior which, while not a cause for administrative rejection, are tangible evidence of an impaired characterological capacity to adapt to the military service.

(2) Overt homosexuality or other forms of sexual deviant practices such as exhibitionism, transvestitism, voyeurism, etc.

(3) Chronic alcoholism or alcohol addiction.

(4) Drug addiction.

(5) Drug abuse characterized by:

(a) The evidence of use of any narcotic drug, barbiturate, amphetamine, or hallucinogenic substance at time of examination when the use cannot be accounted for as the result of the advice of a recognized health care practitioner.

(b) Use, other than that prescribed by a recognized health care practitioner of any narcotic drug within a 1-year period prior to examination.

(c) The repeated use of any drug or chemical substance, including marijuana, with such frequency that it appears that the examinee has accepted the use of or reliance on these substances as part of the examinee's pattern of behavior (see also TB MED 290; NAVMED P-5116; AFP 160-33).

(d) Those instances of use of marijuana (not habitual use) or experimental or casual use of other drugs, except as indicated in (b) above, may be waived by competent authority, as established by the respective service, providing there is no history of repeated drug uses and there is evidence of current drug abstinence and the individual is otherwise qualified for service.

(6) Alcohol abuse. The cause of rejection for appointment, enlistment, and induction is the repeated irresponsible use of alcoholic beverages which leads to misconduct, unacceptable social be-

havior or impairment of an individual's performance in the examinee's place of employment or educational facility, physical or mental health, financial responsibility or personal relationships within 1 year of examination (see also TB MED 290; NAVMED P-5116; AFP 160-33).

(b) Character and behavior disorders where it is evident by history and objective examination that the degree of immaturity, instability, personality inadequacy, and dependency will seriously interfere with adjustment in the military service as demonstrated by repeated inability to maintain reasonable adjustment in school, with employers and fellow-workers, and other society groups.

(c) Other symptomatic immaturity disorders such as:

(1) Stammering, stuttering, or lisping which interferes with the individual's ability to pronounce and enunciate words promptly and clearly.

(2) Enuresis or history thereof persisting into late childhood or adolescence. (See also article 15-16(3)(c).)

(3) Sleepwalking or history thereof persisting into late childhood or adolescence.

(d) Specific learning defects as listed in International Classification of Diseases, current edition.

15-24. Skin and Cellular Tissues

(1) The skin shall be carefully inspected for evidence of disease. The examination should be conducted in a well-lighted room, preferably by daylight. The condition of the skin often reflects the presence of pathology in other parts of the body as well, and for this reason the dermatological examination is important in evaluating the general physical condition of the individual and as a clue to the existence of lesions elsewhere in the body. As a general rule, applicants who are extensively infested with vermin, and filthy in person and clothing, should be rejected as unsuited for military service.

(2) The following are causes for rejection:

(a) Acne: Severe, when the face is markedly disfigured, or when extensive involvement of the neck, shoulders, chest, or back would be aggravated by environmental conditions or interfere with the wearing of military equipment.

(b) Atopic dermatitis (neurodermatitis disseminata): With active or residual lesions in characteristic areas (face and neck, antecubital and popliteal fossae, occasionally wrists and hands), or documented history thereof.

(c) Cysts:

(1) Cysts, other than pilonidal, of such a size or location as to interfere with the normal wearing of military equipment.

(2) Pilonidal cyst or sinus, if evidenced by presence of readily palpable tumor mass, or if there is a history of inflammation or of purulent discharge.

- (d) Dermatitis factitia.
- (e) Dermatitis herpetiformis.
- (f) Eczema: Any type which is chronic and resistant to treatment.
- (g) Elephantiasis or chronic lymphedema.
- (h) Epidermolysis bullosa.
- (i) Fungal infections, systemic or superficial types (if extensive and not amenable to treatment).
- (j) Furunculosis: Extensive, recurrent, or chronic.
- (k) Hyperhidrosis of hands or feet: Chronic or severe.
- (l) Ichthyosis: Severe.
- (m) Leprosy: Any type.
- (n) Leukemia cutis; mycosis fungoides; Hodgkin's disease.
- (o) Lichen planus.
- (p) Lupus erythematosus (acute, subacute, chronic, or chronic discoid) or any other dermatosis aggravated by sunlight.
- (q) Neurofibromatosis (Von Recklinghausen's disease).
- (r) Nevi or vascular tumors: If extensive, unsightly, or exposed to constant irritation.
- (s) Pemphigus.
- (t) Psoriasis or a verified history thereof.
- (u) Radiodermatitis.
- (v) Scars which are so extensive, deep, or adherent that they may interfere with the wearing of military equipment, or that show a tendency to ulcerate.
- (w) Scleroderma, diffuse type.
- (x) Tattooing which is obscene, offensive, or indecent.
- (y) Tuberculosis.
- (z) Urticaria, chronic.
- (aa) Warts, plantar, on weight bearing areas, if symptomatic.
- (bb) Xanthoma: If disabling or accompanied by hypercholesterolemia or hyperlipemia.

15-25. Spine, Scapulae, Ribs, and Sacroiliac Joints

- (1) Have the applicant perform the exercises described in article 15-99. Examine carefully for evidence of intervertebral disc syndrome, myositis and traumatic lesions of the low back (lumbosacral and sacroiliac strains). If the examination gives any indication of congenital deformity, arthritis, spondylolisthesis, or significant degree of abnormal curvature, special orthopedic consultation and X-ray examination should be obtained.
- (2) *Spine and Sacroiliac Joints.*—The following are causes for rejection:
 - (a) Arthritis (see art. 15-13(4)(a)).
 - (b) Complaint of disease or injury of the spine or sacroiliac joints either with or without

objective signs and symptoms which have prevented the individual from successfully following a physically active vocation in civilian life.

(c) Deviation or curvature of the spine from normal alignment, structure, or function (scoliosis, kyphosis, or lordosis, spina bifida occulta, spondylolysis, spondylolisthesis, etc.), if:

(1) Mobility and weight-bearing power are poor.

(2) More than moderate restriction of normal physical activities is required.

(3) Of such a nature as to prevent the individual from following a physically active vocation in civilian life.

(4) Of a degree which will interfere with the wearing of a uniform or military equipment.

(5) Symptomatic, associated with positive physical finding(s) demonstrable by X-ray.

(d) Diseases of the lumbosacral or sacroiliac joints of a chronic type and obviously associated with pain referred to the lower extremities, muscular spasm, postural deformities or limitation of motion in the lumbar region of the spine.

(e) Granulomatous diseases either active or healed.

(f) Fracture of the spine. Healed fracture or dislocation of the spine in which there are residuals such as significant wedging, malalignment, or abnormal neurological findings present to a degree which would preclude satisfactory performance of service.

(g) Malformation and deformities of the pelvis sufficient to interfere with function.

(h) Ruptured nucleus pulposus (herniation of intervertebral disk) or history of operation for this condition.

(3) *Scapulae, Clavicles, Sternum, and Ribs.*—The following are causes for rejection:

(a) Fractures, until well healed, and until determined that the residuals thereof will not preclude the satisfactory performance of military duty.

(b) Injury within the preceding 6 weeks, without fracture, or dislocation, of more than a minor nature.

(c) Osteomyelitis.

(d) Prominent scapulae interfering with function or with the wearing of uniform or military equipment.

15-26. Systemic Diseases and Miscellaneous Conditions and Defects

(1) *Systemic Diseases.*—The following are causes for rejection:

(a) Dermatomyositis.

(b) Genodermatosis with visceral involvement (adenoma sebaceum, neurofibromatosis (Von Recklinghausen's disease), etc.).

(c) Leprosy: Any type.

(d) Lupus erythematosus: Acute, subacute, chronic, or chronic discoid.

(e) Reiter's disease.

(f) Sarcoidosis.

(g) Progressive systemic sclerosis.

(h) Tuberculosis:

(1) Active tuberculosis in any form or location or substantiated history of active tuberculosis within the previous 2 years.

(2) Substantiated history of one or more reactivations or relapses of tuberculosis in any form or location or other definite evidence of poor host resistance to the tubercle bacillus. (See also art. 15-20(3).)

(3) Residual physical or mental defects from past tuberculosis that would preclude the satisfactory performance of duty.

(i) Vasculitis: Chronic or severe (periarteritis, malignant papulosa atrophicans, pityriasis lichenoides et varioliformis).

(2) *General and Miscellaneous Conditions and Defects.*—The following are causes for rejection:

(a) Allergic manifestations:

(1) Allergic rhinitis (hay fever). (See also art. 15-21.)

(2) Asthma. (See also art. 15-20.)

(3) Allergic dermatoses. (See also art. 15-24.)

(4) Visceral, abdominal or cerebral allergy, if severe.

(5) Bona fide history of moderate or severe generalized (as opposed to local) allergic reaction to insect bites or stings.

(6) Bona fide history of severe generalized reaction to common foods; e.g., milk, eggs, beef, and pork.

(b) Any acute pathological condition, including acute communicable diseases, until recovery has occurred without sequelae.

(c) Any deformity which is markedly unsightly or which impairs general functional ability to such an extent as to prevent satisfactory performance of military duty.

(d) Chronic metallic poisoning especially beryllium, manganese, and mercury. Undesirable residuals from lead, arsenic, or silver poisoning make the examinee medically unacceptable.

(e) Cold injury, residuals of (example: frostbite, chilblain, immersion foot, or trench foot), such as deep seated ache, paresthesia, hyperhidrosis, easily traumatized skin, cyanosis, amputation of any digit, or ankylosis.

(f) Unexplained biological false positive tests for syphilis (positive S.T.S. with negative FTA-ABS).

(g) Filariasis; trypanosomiasis; amebiasis; schistosomiasis; uncinariasis (hookworm) associated with anemia, malnutrition, etc., if more than mild,

and other similar worm or animal parasitic infestations, including the carrier states thereof.

(h) Heat pyrexia (heatstroke, sunstroke, etc.): Documented evidence of predisposition (includes disorders of sweat mechanism and previous serious episodes), recurrent episodes requiring medical attention, or residual injury resulting therefrom (especially cardiac, cerebral, hepatic, and renal).

(i) Industrial solvent and other chemical intoxication, chronic, including carbon bisulfide, trichloroethylene, carbon tetrachloride, and methyl cellosolve.

(j) Mycotic infection of internal organs.

(k) Myositis or fibrositis, severe chronic.

(l) Residuals of tropical fevers and various parasitic or protozoal infestations which in the opinion of the medical examiner preclude the satisfactory performance of military duty.

15-27. Tumors and Malignant Diseases

(1) *Benign Tumors.*—The following are causes for rejection:

(a) Any tumor of the:

(1) Auditory canal, if obstructive.

(2) Bronchus, lung, pleura, or mediastinum.

(3) Central nervous system and its membranous coverings unless 5 years after surgery and no otherwise disqualifying residuals of surgery or original lesion.

(4) Eye or orbit (see also art. 15-14(3)(a)(6)).

(5) Kidney, bladder, testicle, or penis.

(b) Tumor, benign, of:

(1) Abdominal wall, if sufficiently large to interfere with military duty.

(2) Bone, if likely to continue to enlarge, be subject to trauma during military service, or shows malignant potential.

(3) Breast, thorax, or chest wall, other than fibromata, lipomata, and inclusion or sebaceous cysts which do not interfere with military duty.

(4) Female genitalia, internal or external (see also art. 15-16(2)(i)).

(5) Thyroid or other structures of the neck (including enlarged lymph nodes) if the enlargement is of such degree as to interfere with the wearing of a uniform or military equipment.

(6) Tongue, if it interferes with function.

(2) *Malignant Diseases and Tumors.*—The following are causes for rejection:

(a) Leukemia, acute or chronic.

(b) Malignant lymphomata.

(c) Malignant tumor of any kind, at any time, substantiated diagnosis of, even though surgically removed, confirmed by accepted laboratory procedures, except as noted in article 15-14(3)(a)(6).

15-28. Venereal Diseases

(1) *General.*—All applicants for the naval service shall receive serologic test for syphilis. This test shall be conducted at the time of application if the individual is a suspect or presents clinical evidence of venereal disease or has a history thereof. If this test is not conducted at the time of application, it shall be conducted as soon as practicable after reporting to first duty station or Reserve activity, as appropriate.

(2) *Procedure When Serological Test for Syphilis is Positive.*—

(a) All applicants giving a positive serum reaction shall be sufficiently checked, preferably by another laboratory, to assure persistence of reaction and to minimize chance of error. An FTA—ABS test shall be obtained also at the same time to further differentiate biological false positive reactions from syphilis. If required, the facilities of local or State health departments may be utilized for performing serological tests at the time of application.

(b) The possibility of a false positive serologic test for syphilis should be considered in those applicants who have or are convalescent from any acute infectious disease or recent fever from any cause (see biologic false positive reaction, art. 15-26(2)(f)). A persistently positive serologic test for syphilis may or may not signify active syphilis; it may represent a test that is sero-fast or biologic false

positive. There will be applicants, therefore, that may qualify under such circumstances; e.g., those with evidence of adequately treated early syphilis or those with evidence of adequately treated congenital syphilis who show no complications or permanent residual of the disease, etc. (See art. 15-28(3)(c).) Consultation with a syphilologist should be obtained if the solution to the problem of a persistently positive serologic test is not readily apparent.

(c) For all applicants who have clinical evidence of venereal disease, and all personnel with a positive serological test resulting from syphilis which existed prior to entrance in the naval service, the state health department shall be notified of the test results.

(3) *Venereal Diseases.*—The following are causes for rejection:

(a) Any active venereal infection or any active infectious process resulting therefrom.

(b) Venereal disease which has not satisfactorily responded to treatment. The finding of a positive serologic test for syphilis following adequate treatment of syphilis is not in itself considered evidence of venereal disease which has not responded to treatment (see art. 15-26(2)(f)).

(c) Complications and permanent residuals of venereal disease if progressive or of such nature as to interfere with the satisfactory performance of duty, or if subject to aggravation by military service.

Section II. PHYSICAL STANDARDS FOR SPECIAL PERSONNEL GROUPS

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Antarctic-"Operation DEEP FREEZE"	15-37
Marine Security Guard Duty and other State Department Assignments	15-38
Special Duty, Intelligence Officers (163x Designator)	15-39
Firefighting Instructor Personnel	15-41

15-29. General

(1) Certain groups of personnel, by reason of the particular type of duty to which they will be assigned, are required to meet physical standards which differ somewhat from those stated in the preceding section. Some of these groups and the special physical standards which are in effect are considered separately in the articles that follow.

15-30. Induction and Enlistment in the U.S. Navy, U.S. Marine Corps, or Reserve Components Thereof

(1) Chapter 2, Army Regulations 40-501 (Standard of Medical Fitness), contains the

physical standards and causes for rejection for induction and enlistment in the U.S. Navy, U.S. Marine Corps, or Reserve components thereof. When considering an individual for immediate reenlistment or extension of enlistment, refer to article 15-3(4) and SECNAVINST 1850.3 series. For convenience, standards for enlistment with applicable appendices are reprinted on the following pages. Attention is invited to the footnotes at the bottom of certain pages. (Sample: Navy reference for the following articles: 15-30-2-16e(1).)

(2) These standards do not apply for appointment or commissioning in any category, or for the enrollment of officer candidates in any Navy or Marine Corps program.

Section II. ABDOMEN AND GASTROINTESTINAL SYSTEM

2-3. Abdominal Organs and Gastrointestinal System

The causes for rejection for appointment, enlistment, and induction are—

a. *Cholecystectomy*, sequelae of, such as post-operative stricture of the common bile duct, reforming of stones in hepatic or common bile ducts, or incisional hernia, or postcholecystectomy syndrome when symptoms are so severe as to interfere with normal performance of duty.

b. *Cholecystitis*, acute or chronic, with or without cholelithiasis, if diagnosis is confirmed by usual laboratory procedures or authentic medical records.

c. *Cirrhosis* regardless of the absence of manifestations such as jaundice, ascites or known esophageal varices, abnormal liver function tests with or without history of chronic alcoholism.

d. *Fistula* in ano.

e. *Gastritis*, chronic hypertrophic, severe.

f. *Hemorrhoids*:

(1) External hemorrhoids producing marked symptoms.

(2) Internal hemorrhoids, if large or accompanied with hemorrhage or protruding intermittently or constantly.

g. *Hepatitis* within the preceding 6 months, or persistence of symptoms after a reasonable period of time with objective evidence of impairment of liver function.

h. *Hernia*:

(1) Hernia other than small asymptomatic umbilical or hiatal.

(2) History of operation for hernia within the preceding 60 days.

i. *Intestinal obstruction* or authenticated history of more than one episode, if either occurred during the preceding 5 years or if resulting condition remains which produces significant symptoms or requires treatment.

j. *Megacolon* of more than minimal degree, *diverticulitis*, *regional enteritis*, and *ulcerative colitis*. *Irritable colon* of more than moderate degree.

k. *Pancreas*, acute or chronic disease of, if proven by laboratory tests, or authenticated medical records.

l. *Rectum*, stricture or prolapse of.

m. *Resection, gastric or of bowel; or gastro-enterostomy*; however minimal intestinal resection in infancy or childhood (*for example*; for intussusception or pyloric stenosis) is acceptable if the individual has been asymptomatic since the resection and if surgical consultation (to include upper and lower gastrointestinal series) gives complete clearance.

n. *Scars*.

(1) Scars, abdominal, regardless of cause, which show hernial bulging or which interfere with movements.

(2) Scar pain associated with disturbance of function of abdominal wall or contained viscera.

o. *Sinuses* of the abdominal wall.

p. *Splenectomy*, except when accomplished for the following:

(1) Trauma.

(2) Causes unrelated to diseases of the spleen.

(3) Hereditary spherocytosis.

(4) Disease involving the spleen when followed by correction of the condition for a period of at least 2 years.

q. *Tumors*. See paragraphs 2-40 and 2-41.

r. *Ulcer*:

(1) Ulcer of the stomach or duodenum if diagnosis is confirmed by X-ray examination, or authenticated history thereof.

(2) Authentic history of surgical operation(s) for gastric or duodenal ulcer.

s. *Other* congenital or acquired abnormalities and defects which preclude satisfactory performance of military duty or which require frequent and prolonged treatment.

Section III. BLOOD AND BLOOD-FORMING TISSUE DISEASES

2-4. Blood and Blood-Forming Tissue Diseases

The causes for rejection for appointment, enlistment, and induction are—

a. *Anemia*:

(1) Blood less anemia—until both condition and basic cause are corrected.

(2) Deficiency anemia, not controlled by medication.

(3) Abnormal destruction of RBC's: Hemolytic anemia.

(4) Faulty RBC construction: Hereditary hemolytic anemia, thalassemia, and sickle cell anemia.

(5) Myelophthisic anemia: Myelomatosis, leukemia, Hodgkin's disease.

(6) Primary refractory anemia: Aplastic anemia, DiGuglielmo's syndrome.

b. *Hemorrhagic states*:

(1) Due to changes in coagulation system (hemophilia, etc.).

(2) Due to platelet deficiency.

(3) Due to vascular instability.

c. *Leukopenia*, chronic or recurrent associated with increased susceptibility to infection.

d. *Myeloproliferative disease (other than leukemia)*:

(1) Myelofibrosis.

(2) Megakaryocytic myelosis.

(3) Polycythemia vera.

e. *Splenomegaly* until the cause is remedied.

f. *Thromboembolic disease* except for acute, nonrecurrent conditions.

Section IV. DENTAL

2-5. Dental

The causes for rejection for appointment, enlistment, and induction are—

a. *Diseases of the jaws or associated tissues* which are not easily remediable and which will incapacitate the individual or prevent the satisfactory performance of military duty.

b. *Malocclusion, severe*, which interferes with the mastication or a normal diet.

c. *Oral tissues*, extensive loss of, in an amount that would prevent replacement of missing teeth with a satisfactory prosthetic appliance.

d. *Orthodontic appliances*, see special administrative criteria in paragraph 7-16 of AR 40-501. (Individuals who have orthodontic appliances and who are under active treatment are administratively unacceptable for enlistment or induction in the active or Reserve components of the Navy and Marine Corps for an initial period not to exceed 12 months from the date that treatment was initiated. Individuals undergoing orthodontic care are acceptable for enlistment in the Delayed Entry Program or a Reserve Component of the Navy and Marine Corps only if a civilian or a military orthodontist provides documentation that active orthodontic treatment will have been completed prior to entry on initial active duty for training or active duty. Individuals with retainer orthodontic appliances who are not required to undergo active treatment are administratively acceptable for enlistment, induction, initial active duty for training, or active duty status.)

e. Relationship between the mandible and maxilla of such a nature as to preclude future satisfactory prosthodontic replacement.

2-6. Ears

The causes for rejection for appointment, enlistment, and induction are—

a. *Auditory canal*.

(1) Atresia or severe stenosis of the external auditory canal.

(2) Tumors of the external auditory canal except mild exostoses.

(3) Severe external otitis, acute or chronic.

b. *Auricle*. Agenesis, severe; or severe traumatic deformity, unilateral or bilateral.

c. *Mastoids*.

(1) Mastoiditis, acute or chronic.

(2) Residual or mastoid operation with marked external deformity which precludes or interferes with the wearing of a gas mask or helmet.

(3) Mastoid fistula.

d. *Meniere's syndrome*.

e. *Middle ear*.

(1) Acute or chronic suppurative otitis media. Individuals with a recent history of acute suppurative otitis media will not be accepted unless the condition is healed and a sufficient interval of time subsequent to treatment has elapsed to insure that the disease is in fact not chronic.

(2) Adhesive otitis media associated with hearing level by audiometric test of 20 db or more average for the speech frequencies (500, 1000, and 2000 cycles per second) in either ear regardless of the hearing level in the other ear.

(3) Acute or chronic serous otitis media.

(4) Presence of attic perforation in which presence of cholesteatoma is suspected.

(5) Repeated attacks of catarrhal otitis media; intact greyish, thickened drum(s).

f. *Tympanic membrane*.

(1) Any perforation of the tympanic membrane.

(2) Severe scarring of the tympanic membrane associated with hearing level by audiometric test of 20 db or more average for the speech frequencies (500, 1000, and 2000 cycles per second) in either ear regardless of the hearing level in the other ear.

g. *Other diseases and defects of the ear* which obviously preclude satisfactory performance of duty or which require frequent and prolonged treatment.

2-7. Hearing

(See also para 2-6.)

The cause for rejection for appointment, enlistment, and induction is—

Hearing acuity level by audiometric testing (regardless of conversational or whispered voice hearing acuity) greater than that described in table I, appendix II. There is no objection to conducting the whispered voice test or the spoken voice test as a preliminary to conducting the audiometric hearing test.

Section VI. ENDOCRINE AND METABOLIC DISORDERS

2-8. Endocrine and Metabolic Disorders

The causes for rejection for appointment, enlistment, and induction are—

- a. *Adrenal gland*, malfunction of, of any degree.
- b. *Cretinism*.
- c. *Diabetes insipidus*.
- d. *Diabetes mellitus*.
- e. *Gigantism or acromegaly*.
- f. *Glycosuria*, persistent, regardless of cause.
- g. *Goiter*.

(1) Simple goiter with definite pressure symptoms or so large in size as to interfere with the wearing of a military uniform or military equipment.

(2) *Thyrotoxicosis*.

- h. *Gout*.

- i. *Hyperinsulinism*, confirmed, symptomatic.
- j. *Hyperparathyroidism and hypoparathyroidism*.
- k. *Hypopituitarism*, severe.
- l. *Myxedema*, spontaneous or postoperative (with clinical manifestations and not based solely on low basal metabolic rate).
- m. *Nutritional deficiency diseases* (including sprue, beriberi, pellagra, and scurvy) which are more than mild and not readily remediable or in which permanent pathological changes have been established.
- n. *Other endocrine or metabolic disorders* which obviously preclude satisfactory performance of duty or which require frequent and prolonged treatment.

Section VII. EXTREMITIES

2-9. Upper Extremities

(See para 2-11.)

The causes for rejection for appointment, enlistment, and induction are—

- ★ a. *Limitation of motion*. An individual will be considered unacceptable if the joint ranges of motion are less than the measurements listed below (TM 8-640).

(1) *Shoulder*.

- (a) Forward elevation to 90°.
- (b) Abduction to 90°.

(2) *Elbow*.

- (a) Flexion to 100°.
- (b) Extension to 15°.

(3) *Wrist*. A total range of 15° (extension plus flexion).

(4) *Hand*.

(a) Pronation to the first quarter of normal arc.

(b) Supination to the first quarter of the normal arc.

(5) *Fingers*. Inability to clench first, pick up a pin or needle, and grasp an object.

b. *Hand and fingers*.

(1) Absence (or loss) of more than 1/3 of the distal phalanx of either thumb.

(2) Absence (or loss) of distal and middle phalanx of an index, middle or ring finger of either hand irrespective of the absence (or loss) of little finger.

(2.1) Absence of more than the distal phalanx of any two of the following fingers, index, middle finger or ring finger, of either hand.

(3) Absence of hand or any portion thereof except for fingers as noted above.

(4) Hyperdactylia.

(5) Scars and deformities of the fingers and/or hand which impair circulation, are symptomatic, are so disfiguring as to make the individual objectionable in ordinary social relationships, or which impair normal function to such a degree as to interfere with the satisfactory performance of military duty.

c. *Wrist, forearm, elbow, arm, and shoulder*. Healed disease or injury of wrist, elbow, or shoulder with residual weakness or symptoms of such a degree as to preclude satisfactory performance of duty.

2-10. Lower Extremities

(See para 2-11.)

The causes for rejection for appointment, enlistment, and induction are—

★ a. *Limitation of motion.* An individual will be considered unacceptable if the joint ranges of motion are less than the measurements listed below (TM 8-640).

(1) *Hip.*

- (a) Flexion to 90°.
- (b) Extension to 10° (beyond 0).

(2) *Knee.*

- (a) Full extension.
- (b) Flexion to 90°.

(3) *Ankle.*

- (a) Dorsiflexion to 10°.
- (b) Plantar flexion to 10°.

(4) *Toes.* Stiffness which interferes with walking, marching, running, or jumping.

b. *Foot and ankle.*

(1) Absence of one or more small toes of one or both feet, if function of the foot is poor or running or jumping is precluded, or absence of foot or any portion thereof except for toes as noted herein.

(2) Absence (or loss) of great toe(s) or loss of dorsal flexion thereof if function of the foot is impaired.

(3) Claw toes precluding the wearing of combat service boots.

(4) Clubfoot.

(5) Flatfoot, pronounced cases, with decided eversion of the foot and marked bulging of the inner border, due to inward rotation of the astragalus, regardless of the presence or absence of symptoms.

(6) Flatfoot, spastic.

(7) Hallux valgus, if severe and associated with marked exostosis or bunion.

(8) Hammer toe which interferes with the wearing of combat service boots.

(9) Healed disease, injury, or deformity including hyperdactylia which precludes running, is accompanied by disabling pain, or which prohibits wearing of combat service boots.

(10) Ingrowing toe nails, if severe, and not remediable.

(11) Obliteration of the transverse arch associated with permanent flexion of the small toes.

(12) Pes cavus, with contracted plantar fascia, dorsiflexed toes, tenderness under the meta-

tarsal heads, and callosity under the weight bearing areas.

c. *Leg, knee, thigh, and hip.*

(1) Dislocated semilunar cartilage, loose or foreign bodies within the knee joint, or history of surgical correction of same if—

(a) Within the preceding 6 months.

(b) Six months or more have elapsed since operation without recurrence, and there is instability of the knee ligaments in lateral or anteroposterior directions in comparison with the normal knee or abnormalities noted on X-ray, there is significant atrophy or weakness of the thigh musculature in comparison with the normal side, there is not acceptable active motion in flexion and extension, or there are other symptoms of internal derangement.

(2) Authentic history or physical findings of an unstable or internally deranged joint causing disabling pain or seriously limiting function. Individuals with verified episodes of buckling or locking of the knee who have not undergone satisfactory surgical correction or if, subsequent to surgery, there is evidence of more than mild instability of the knee ligaments in lateral and anteroposterior directions in comparison with the normal knee, weakness or atrophy of the thigh musculature in comparison with the normal side, or if the individual requires medical treatment of sufficient frequency to interfere with the performance of military duty.

d. *General.*

(1) Deformities of one or both lower extremities which have interfered with function to such a degree as to prevent the individual from following a *physically active* vocation in civilian life or which would interfere with the satisfactory completion of prescribed training and performance of military duty.

(2) Diseases or deformities of the hip, knee, or ankle joint which interfere with walking, running, or weight bearing.

(3) Pain in the lower back or leg which is intractable and disabling to the degree of interfering with walking, running, and weight bearing.

(4) Shortening of a lower extremity resulting in any limp of noticeable degree.

2-11. Miscellaneous

(See also para 2-9 and 2-10.)

The causes for rejection for appointment, enlistment, and induction are—

a. Arthritis.

(1) Active or subacute arthritis, including Marie-Strumpell type.

(2) Chronic osteoarthritis or traumatic arthritis of isolated joints of more than minimal degree, which has interfered with the following of a physically active vocation in civilian life or which precludes the satisfactory performance of military duty.

(3) Documented clinical history of rheumatoid arthritis.

(4) Traumatic arthritis of a major joint of more than minimal degree.

b. Disease of any bone or joint, healed, with such resulting deformity or rigidity that function is impaired to such a degree that it will interfere with military service.

c. Dislocation, old unreduced; substantiated history of recurrent dislocations of major joints; instability of a major joint, symptomatic and more than mild; or if, subsequent to surgery, there is evidence of more than mild instability in comparison with the normal joint, weakness or atrophy in comparison with the normal side, or if the individual requires medical treatment of sufficient frequency to interfere with the performance of military duty.

d. Fractures.

(1) Malunited fractures that interfere significantly with function.

(2) Ununited fractures.

(3) Any old or recent fracture in which a plate, pin, or screws were used for fixation and left in place and which may be subject to easy trauma, i.e., as a plate tibia, etc.

e. Injury of a bone or joint within the preceding 6 weeks, without fracture or dislocation, of more than a minor nature.

f. Muscular paralysis, contracture, or atrophy, if progressive or of sufficient degree to interfere with military service.

f.1. Myotonia congenita. Confirmed.

g. Osteomyelitis, active or recurrent, of any bone or substantiated history of osteomyelitis of any of the long bones unless successfully treated 2 or more years previously without subsequent recurrence or disqualifying sequelae as demonstrated by both clinical and X-ray evidence.

h. Osteoporosis.

i. Scars, extensive, deep, or adherent, of the skin and soft tissues or neuromas of an extremity which are painful, which interfere with muscular movements, which preclude the wearing of military equipment, or that show a tendency to break down.

j. Chondromalacia, manifested by verified history of joint effusion, interference with function, or residuals from surgery.

Section VIII. EYES AND VISION**2-12. Eyes**

The causes for rejection for appointment, enlistment, and induction are—

a. Lids.

(1) Blepharitis, chronic more than mild. Cases of acute blepharitis will be rejected until cured.

(2) Blepharospasm.

(3) Dacryocystitis, acute or chronic.

(4) Destruction of the lids, complete or extensive, sufficient to impair protection of the eye from exposure.

(5) Disfiguring cicatrices and adhesions of the eyelids to each other or to the eyeball.

(6) Growth or tumor of the eyelid other than small early basal cell tumors of the eyelid, which can be cured by treatment, and small nonprogressive asymptomatic benign lesions. See also paragraphs 2-40 and 2-41.

(7) Marked inversion or eversion of the eyelids sufficient to cause unsightly appearance or watering of eyes (entropion or ectropion).

(8) Lagophthalmos.

- (9) Ptosis interfering with vision.
- (10) Trichiasis, severe.

b. *Conjunctiva.*

(1) Conjunctivitis, chronic, including vernal catarrh and trachoma. Individuals with acute conjunctivitis are unacceptable until the condition is cured.

(2) Pterygium:

(a) Pterygium recurring after three operative procedures.

(b) Pterygium encroaching on the cornea in excess of 3 millimeters or interfering with vision.

c. *Cornea.*

(1) Dystrophy, corneal, of any type including keratoconus of any degree.

(2) Keratitis, acute or chronic.

(3) Ulcer, corneal; history of recurrent ulcers or corneal abrasions (including herpetic ulcers).

★ (4) Vascularization or opacification of the cornea from any cause which is progressive or reduces vision below the standards prescribed in paragraph 2-13.

d. *Uveal tract.* Inflammation of the uveal tract except healed traumatic choroiditis.

e. *Retina.*

(1) Angiomas, phakomas, retinal cysts, and other congenito-hereditary conditions that impair visual function.

(2) Degenerations of the retina to include macular cysts, holes, and other degenerations (hereditary or acquired degenerative changes) and other conditions affecting the macula. All types of pigmentary degenerations (primary and secondary).

(3) Detachment of the retina or history of surgery for same.

(4) Inflammation of the retina (retinitis or other inflammatory conditions of the retina to include Coat's disease, diabetic retinopathy, Eales' disease, and retinitis proliferans).

f. *Optic nerve.*

(1) Congenito-hereditary conditions of the optic nerve or any other central nervous system pathology affecting the efficient function of the optic nerve.

(2) Optic neuritis, neuroretinitis, or secondary optic atrophy resulting therefrom or document history of attacks of retrobulbar neuritis.

(3) Optic atrophy (primary or secondary).

(4) Papilledema.

g. *Lens.*

(1) Aphakia (unilateral or bilateral).

(2) Dislocation, partial or complete, of a lens.

(3) Opacities of the lens which interfere with vision or which are considered to be progressive.

h. *Ocular mobility and motility.*

(1) Diplopia, documented, constant or intermittent from any cause or of any degree interfering with visual function (i.e., may suppress).

(2) Diplopia, monocular, documented, interfering with visual function.

(3) Nystagmus, with both eyes fixing, congenital or acquired.

(4) Strabismus of 40 prism diopters or more, uncorrectable by lens to less than 40 diopters.

(5) Strabismus of any degree accompanied by documented diplopia.

(6) Strabismus, surgery for the correction of, within the preceding 6 months.

i. *Miscellaneous defects and diseases.*

(1) Abnormal conditions of the eye or visual fields due to diseases of the central nervous system.

(2) Absence of an eye.

(3) Asthenopia severe.

(4) Exophthalmos, unilateral or bilateral.

(5) Glaucoma, primary or secondary.

(6) Hemianopsia of any type.

(7) Loss of normal pupillary reflex reactions to light or accommodation to distance or Adies syndrome.

(8) Loss of visual fields due to organic disease.

(9) Night blindness associated with objective disease of the eye. Verified congenital night blindness.

(10) Residuals of old contusions, lacerations.

tions, penetrations, etc., which impair visual function required for satisfactory performance of military duty.

(11) Retained intra-ocular foreign body.

(12) Tumors. See a(6) above and paragraphs 2-40 and 2-41.

(13) Any organic disease of the eye or adnexa not specified above which threatens continuity of vision or impairment of visual function.

2-13. Vision

The causes for medical rejection for appointment, enlistment, and induction are listed below. The special administrative criteria for officer assignment to Armor, Artillery, Infantry, Corps of Engineers, Signal Corps, and Military Police Corps are listed in paragraph 7-15.

★ a. *Distant visual acuity.* Distant visual acuity of any degree which does not correct with spectacle lenses to at least one of the following:

(1) 20/40 in one eye and 20/70 in the other eye.

(2) 20/30 in one eye and 20/100 in the other eye.

(3) 20/20 in one eye and 20/400 in the other eye.

b. *Near visual acuity.* Near visual acuity of any degree which does not correct to at least J-6 in the better eye.

c. *Refractive error.* Any degree of refractive error in spherical equivalent of over -8.00 or +8.00; or if ordinary spectacles cause discomfort by reason of ghost images, prismatic displacement, etc.; or if an ophthalmological consultation reveals a condition which is disqualifying.

d. *Contact lens.* Complicated cases requiring contact lens for adequate correction of vision as keratoconus, corneal scars, and irregular astigmatism.

Section IX. GENITOURINARY SYSTEM

2-14. Genitalia

(See also para 2-40 and 2-41.)

The causes for rejection for appointment, enlistment, and induction are—

a. *Burtholinitis*, Bartholin's cyst.

b. *Cervicitis*, acute or chronic manifested by leukorrhea.

c. *Dysmenorrhea*, incapacitating to a degree which necessitates recurrent absences of more than a few hours from routine activities.

d. *Endometriosis*, or confirmed history thereof.

e. *Hermaphroditism*.

f. *Menopausal syndrome*, either physiologic or artificial if manifested by more than mild constitutional or mental symptoms, or artificial menopause if less than 13 months have elapsed since cessation of menses. In all cases of artificial menopause, the clinical diagnosis will be reported; if accomplished by surgery, the pathologic report will be obtained and recorded.

g. *Menstrual cycle*, irregularities of, including menorrhagia, if excessive; metrorrhagia; polymenorrhea; amenorrhea, except as noted in f above.

h. *New growths of the internal or external genitalia* except single uterine fibroid, subser-

ous, asymptomatic, less than 3 centimeters in diameter, with no general enlargement of the uterus. See also paragraphs 2-40 and 2-41.

- i. *Oophoritis*, acute or chronic.
- j. *Ovarian cysts*, persistent and considered to be of clinical significance.
- k. *Pregnancy*.
- l. *Salpingitis*, acute or chronic.
- m. *Testicle(s)*. (See also para 2-40 and 2-41.)
 - (1) Absence or nondescent of both testicles.
 - (2) Undiagnosed enlargement or mass of testicle or epididymis.
 - (3) Undescended testicle.
- n. *Urethritis*, acute or chronic, other than gonorrheal urethritis without complications.
- o. *Uterus*.
 - (1) Cervical polyps, cervical ulcer, or marked erosion.
 - (2) Endocervicitis, more than mild.
 - (3) Generalized enlargement of the uterus due to any cause.
 - (4) Malposition of the uterus if more than mildly symptomatic.
- p. *Vagina*.
 - (1) Congenital abnormalities or severe lacerations of the vagina.
 - (2) Vaginitis, acute or chronic, manifested by leukorrhea.
- q. *Varicocele or hydrocele*, if large or painful.
- r. *Vulva*.
 - (1) Leukoplakia.
 - (2) Vulvitis, acute or chronic.
- s. *Major abnormalities and defects of the genitalia* such as a change of sex, a history thereof, or complications (adhesions, disfiguring scars, etc.) residual to surgical correction of these conditions.

2-15. Urinary System

(See para 2-8, 2-40, and 2-41.)

The causes for rejection for appointment, enlistment, and induction are—

- a. *Albuminuria* if persistent or recurrent including so-called orthostatic or functional albuminuria.
- b. *Cystitis, chronic*. Individuals with acute cystitis are unacceptable until the condition is cured.
- c. *Enuresis* determine to be a symptom of an organic defect not amenable to treatment. (See also para 2-34c.)
- d. *Epispadias or hypospadias* when accompanied by evidence of infection of the urinary tract or if clothing is soiled when voiding.
- e. *Hematuria, cylindruria*, or other findings indicative of renal tract disease.
- f. *Incontinence* of urine.
- g. *Kidney*.
 - (1) Absence of one kidney, regardless of cause.
 - (2) Acute or chronic infections of the kidney.
 - (3) Cystic or polycystic kidney, confirmed history of.
 - (4) Hydronephrosis or pyonephrosis.
 - (5) Nephritis, acute or chronic.
 - (6) Pyelitis, pyelonephritis.
- h. *Penis*, amputation of, if the resulting stump is insufficient to permit micturition in a normal manner.
- i. *Peyronie's disease*.
- j. *Prostate gland*, hypertrophy of, with urinary retention.
- k. *Renal calculus*.
 - (1) Substantiated history of bilateral renal calculus at any time.
 - (2) Verified history of renal calculus at any time with evidence of stone formation within the preceding 12 months, current symptoms or positive X-ray for calculus.
- l. *Skeneitis*.
- m. *Urethra*.
 - (1) Stricture of the urethra.
 - (2) Urethritis, acute or chronic, other than gonorrheal urethritis without complications.
- n. *Urinary fistula*.

o. *Other diseases and defects of the urinary system* which obviously preclude satisfactory perform-

ance of duty or which require frequent and prolonged treatment.

Section X. HEAD AND NECK

2-16. Head

The causes for rejection for appointment, enlistment, and induction are—

a. *Abnormalities* which are apparently temporary in character resulting from recent injuries until a period of 3 months has elapsed. These include severe contusions and other wounds of the scalp and cerebral concussion. See paragraph 2-31.

b. *Deformities of the skull* in the nature of depressions, exostoses, etc., of a degree which would prevent the individual from wearing a gas mask or military headgear.

c. *Deformities of the skull of any degree* associated with evidence of disease of the brain, spinal cord, or peripheral nerves.

d. *Depressed fractures near central sulcus* with or without convulsive seizures.

e. *Loss or congenital absence* of the bony substance of the skull not successfully corrected by reconstructive material:

(1) All cases involving absence of the bony substance of the skull which have been corrected but in which the defect is in excess of 1 square inch or the size of a 25 cent piece, will be referred to The Surgeon General* together with a report of consultation.

(2) The report of consultation will include an evaluation of any evidence of alteration of brain function in any of its several spheres, i.e., intelligence, judgment, perception, behavior, motor control and sensory function as well as any evidence of active

bone disease or other related complications. Current X-rays and other pertinent laboratory data will accompany such a report of consultation.

f. *Unightly deformities*, such as large birthmarks, large hairy moles, extensive scars, and mutilations due to injuries or surgical operations; ulcerations; fistulae, atrophy, or paralysis of part of the face or head.

2-17. Neck

The causes for rejection for appointment, enlistment, and induction are—

a. *Cervical ribs* if symptomatic, or so obvious that they are found on routine physical examination. (Detection based primarily on X-ray is not considered to meet this criterion.)

b. *Congenital cysts* of branchial cleft origin or those developing from the remnants of the thyroglossal duct, with or without fistulous tracts.

c. *Fistula*, chronic draining, of any type.

d. (Deleted)

e. *Nonspastic contraction* of the muscles of the neck or cicatricial contracture of the neck to the extent that it interferes with the wearing of a uniform or military equipment or so disfiguring as to make the individual objectionable in common social relationships.

f. *Spastic contraction* of the muscles of the neck, persistent, and chronic.

g. *Tumor of thyroid or other structures of the neck*. See paragraphs 2-40 and 2-41.

Section XI. HEART AND VASCULAR SYSTEM

2-18. Heart

The causes for rejection for appointment, enlistment, and induction are—

a. *All organic valvular diseases of the heart*, in-

cluding those improved by surgical procedures.

b. *Coronary artery disease or myocardial infarction*, old or recent or true angina pectoris, at any time.

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c. *Electrocardiographic evidence* of major arrhythmias such as—

(1) Atrial tachycardia, flutter, or fibrillation, ventricular tachycardia or fibrillation.

(2) Conduction defects such as first degree atrio-ventricular block and right bundle branch block. (These conditions occurring as isolated findings are not unfitting when cardiac evaluation reveals no cardiac disease.)

(3) Left bundle branch block, 2d and 3d degree AV block.

(4) Unequivocal electrocardiographic evidence of old or recent myocardial infarction; coronary insufficiency at rest or after stress; or evidence of heart muscle disease.

d. *Hypertrophy or dilatation of the heart* as evidenced by clinical examination or roentgenographic examination and supported by electrocardiographic examination. Care should be taken to distinguish abnormal enlargement from increased distolic filling as seen in the well conditioned subject with a sinus bradycardia. Cases of enlarged heart by X-ray not supported by electrocardiographic examination will be forwarded to The Surgeon General* for evaluation.

e. *Myocardial insufficiency* (congestive circulatory failure, cardiac decompensation) obvious or covert, regardless of cause.

f. *Paroxysmal tachycardia* within the preceding 5 years, or at any time if recurrent or disabling or if associated with electrocardiographic evidence of accelerated A-V conduction (Wolff-Parkinson-White).

g. *Pericarditis; endocarditis; or myocarditis*, history or finding of, except for a history of a single acute idiopathic or coxsackie pericarditis with no residuals, or tuberculous pericarditis adequately treated with no residuals and inactive for 2 years.

n. *Tachycardia* persistent with a resting pulse rate of 100 or more, regardless of cause.

2-19. Vascular System

The causes for rejection for appointment, enlistment, and induction are—

a. *Congenital or acquired lesions of the aorta and major vessels*, such as syphilitic aortitis, demon-

strable atherosclerosis which interferes with circulation, congenital or acquired dilation of the aorta (especially if associated with other features of Marfan's syndrome), and pronounced dilatation of the main pulmonary artery.

b. *Hypertension* evidenced by preponderant diastolic blood pressure over 90 mm or preponderant systolic blood pressure over 159 mm at any age.

c. *Marked circulatory instability* as indicated by orthostatic hypotension, persistent tachycardia, severe peripheral vasomotor disturbances and sympatheticotonia.

d. *Peripheral vascular disease* including Raynaud's phenomena, Buerger's disease (thromboangiitis obliterans), erythromelalgia, arteriosclerotic and diabetic vascular diseases. Special tests will be employed in doubtful cases.

e. *Thrombophlebitis*.

(1) History of thrombophlebitis with persistent thrombus or evidence of circulatory obstruction or deep venous incompetence in the involved veins.

(2) Recurrent thrombophlebitis.

f. *Varicose veins*, if more than mild, or if associated with edema, skin ulceration, or residual scars from ulceration.

2-20. Miscellaneous

The causes for rejection for appointment, enlistment, and induction are—

a. *Aneurysm of the heart or major vessel*, congenital or acquired.

b. *History and evidence of a congenital abnormality* which has been treated by surgery but with residual abnormalities or complications, for example: Patent ductus arteriosus with residual cardiac enlargement or pulmonary hypertension; resection of a coarctation of the aorta without a graft when there are other cardiac abnormalities or complications; closure of a secundum type atrial septal defect when there are residual abnormalities or complications.

c. *Major congenital abnormalities and defects by the heart and vessels* unless satisfactorily corrected without residuals or complications. Uncom-

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plicated dextrocardia and other minor asymptomatic anomalies are acceptable.

d. *Substantiated history of rheumatic fever or*

chorea within the previous 2 years, recurrent attacks of rheumatic fever or chorea at any time, or with evidence of residual cardiac damage.

Section XII. HEIGHT, WEIGHT, AND BODY BUILD

2-21. Height

The causes for rejection for appointment, enlistment, and induction are—

a. *For appointment.*

(1) *Men.* Regular Army—Height below 66 inches or over 80 inches. (See administrative criteria in para 7-13.) Other—Height below 60 inches or over 80 inches.

(2) *Women.* Height below 58 inches or over 72 inches.

b. *For enlistments and induction.*

(1) *Men.* Height below 60 inches or over 80 inches for Army and Air Force.

(2) *Men.* Height below 60 inches and over 78 inches for Navy and Marine Corps.

(3) *Women.* Height below 58 inches or over 72 inches [78 inches for enlistment of female applicants in the Navy].

2-22. Weight

The causes for rejection for appointment, enlistment, and induction are—

a. *Weight related to height* which is below the minimum shown in table I, appendix III for men and table II, appendix III for women. [See art. 15-19, table 3, for female standards for Navy enlistment.]

b. *Weight related to age and height* which is in excess of the maximum shown in table I, appendix III for men and table II, appendix III for women. See chapter 7 for special requirements pertaining to maximum weight standards applicable to women enlisting for and commissioned from Army Student Nurse and Army Student Dietician Programs.

2-23. Body Build

The causes for rejection for appointment, enlistment, and induction are—

a. *Congenital malformation of bones and joints.* (See para 2-9, 2-10, and 2-11.)

b. *Deficient muscular development* which would interfere with the completion of required training.

c. *Evidences of congenital asthenia* (slender bones; weak thorax; visceroptosis; severe, chronic constipation; or "drop-heart" if marked in degree).

d. *Obesity.* Even though the individual's weight is within the maximum shown in table I or II, as appropriate, appendix III, he will be reported as medically unacceptable when the medical examiner considers that the individual's weight in relation to the bony structure and musculature, constitutes obesity of such a degree as to interfere with the satisfactory completion of prescribed training.

Section XIII. LUNGS AND CHEST WALL

2-24. General

The following conditions are causes for rejection for appointment, enlistment and induction until further study indicates recovery without disqualifying sequelae:

a. *Abnormal elevation of the diaphragm* on either side.

b. *Acute abscess* of the lung.

c. *Acute bronchitis* until the condition is cured.

d. *Acute fibrinous pleurisy*, associated with acute nontuberculous pulmonary infection.

e. *Acute mycotic disease* of the lung such as coccidioidomycosis and histoplasmosis.

f. *Acute nontuberculous pneumonia.*

g. *Foreign body in trachea or bronchus.*

h. *Foreign body of the chest wall* causing symptoms.

i. *Lobectomy*, history of, for a nontuberculous nonmalignant lesion with residual pulmonary disease. Removal of more than one lobe is cause for rejection regardless of the absence of residuals.

j. *Other traumatic lesions* of the chest or its contents.

k. *Pneumothorax* or history thereof within 1 year of date of examination if due to simple trauma or surgery; within 3 years of date of examination if of spontaneous origin. Surgical correction is acceptable if no significant residual disease or deformity remains and pulmonary function tests are within normal limits.

l. *Recent fracture* of ribs, sternum, clavicle or scapula.

m. *Significant abnormal findings* on physical examination of the chest.

2-25. Tuberculous Lesions

(See para 2-38.)

The causes for rejection for appointment, enlistment, and induction are—

a. *Tuberculosis*, active at any time within the past 2 years, in any form or location. A positive tuberculin skin test without other evidence of active disease is not disqualifying. Individuals taking prophylactic chemotherapy because of recent skin test conversion are not disqualified.

b. Rescinded.

c. Substantiated history of one or more reactivations or relapses of pulmonary tuberculosis, or other definite evidence of poor host resistance to the tubercle bacillus.

2-26. Nontuberculous Lesions

The causes for rejection for appointment, enlistment, and induction are—

a. *Acute mastitis*, chronic cystic mastitis, if more than mild.

b. *Bronchial asthma*, except for childhood asthma with a trustworthy history of freedom from symptoms since the 12th birthday.

c. *Bronchitis*, chronic with evidence of pulmonary function disturbance.

d. *Bronchiectasis*.

e. *Bronchopleural fistula*.

f. *Bullous or generalized pulmonary emphysema*.

g. *Chronic abscess of lung*.

h. *Chronic fibrous pleuritis* of sufficient extent to interfere with pulmonary function or obscure the lung field in the roentgenogram.

i. *Chronic mycotic diseases* of the lung including coccidioidomycosis; residual cavitation or more than a few small sized inactive and stable residual modules demonstrated to be due to mycotic disease.

j. *Empyema*, residual sacculation or unhealed sinuses of chest wall following operation for empyema.

k. *Extensive pulmonary fibrosis* from any cause, producing dyspnea on exertion.

l. *Foreign body of the lung or mediastinum* causing symptoms or active inflammatory reaction.

m. *Multiple cystic disease* of the lung or solitary cyst which is large and incapacitating.

n. *New growth of breast; history of mastectomy*.

o. *Osteomyelitis* of rib, sternum, clavicle, scapula, or vertebra.

p. *Pleurisy with effusion* of unknown origin within the previous 2 years.

q. *Sarcoidosis*. See paragraph 2-38.

r. *Suppurative periostitis* of rib, sternum, clavicle, scapula, or vertebra.

Section XIV. MOUTH, NOSE, PHARYNX, TRACHEA, ESOPHAGUS, AND LARYNX

2-27. Mouth

The causes for rejection for appointment, enlistment, and induction are—

a. *Hard palate*, perforation of.

b. *Harelip*, unless satisfactorily repaired by surgery.

c. *Leukoplakia*, if severe.

d. *Lips*, unsightly mutilations of, from wounds, burns, or disease.

e. *Ranula*, if extensive. For other tumors see paragraphs 2-10 and 2-41.

2-28. Nose

The causes for rejection for appointment, enlistment, and induction are—

a. *Allergic manifestations*.

(1) Chronic atrophic rhinitis.

(2) Hay fever if severe; and if not controllable by antihistamines or by desensitization, or both.

b. *Choana, atresia, or stenosis* of, if symptomatic.

c. *Nasal septum*, perforation of:

★ (1) Associated with the interference of function, ulceration or crusting, and when the result of organic disease.

(2) If progressive.

(3) If respiration is accompanied by a whistling sound.

d. *Sinusitis*, acute.

e. *Sinusitis*, chronic, when more than mild:

(1) Evidenced by any of the following:

Chronic purulent nasal discharge, large nasal polyps, hyperplastic changes of the nasal tissues, or symptoms requiring frequent medical attention.

(2) Confirmed by transillumination of X-ray examination or both.

2-29. Pharynx, Trachea, Esophagus, and Larynx

The causes for rejection for appointment, enlistment, and induction are—

a. *Esophagus*, organic disease of, such as ulceration, varices, achalasia; peptic esophagitis; if confirmed by appropriate X-ray or esophagoscopy examinations.

b. *Laryngeal paralysis*, sensory or motor, due to any cause.

c. *Larynx*, organic disease of, such as neoplasm, polyps, granuloma, ulceration, and chronic laryngitis.

★ d. *Plica dysphonia ventricularis*.

e. *Tracheostomy or tracheal fistula*.

2-30. Other Defects and Diseases

The causes for rejection for appointment, enlistment, and induction are—

a. *Aphonia*.

b. *Deformities or conditions of the mouth, throat, pharynx, larynx, esophagus, and nose* which interfere with mastication and swallowing of ordinary food, with speech, or with breathing.

c. *Destructive syphilitic disease of the mouth, nose, throat, larynx, or esophagus* (para 2-42).

d. *Pharyngitis and nasopharyngitis*, chronic, with positive history and objective evidence, if of such a degree as to result in excessive time lost in the military environment.

Section XV. NEUROLOGICAL DISORDERS

2-31. Neurological Disorders

The causes for rejection for appointment, enlistment, and induction are—

a. *Degenerative disorders*.

(1) Cerebellar and Friedreich's ataxia.

(2) Cerebral arteriosclerosis.

(3) Encephalomyelitis, residuals of, which preclude the satisfactory performance of military duty.

(4) Huntington's chorea.

(5) Multiple sclerosis.

(6) Muscular atrophies and dystrophies of any type.

*b. *Miscellaneous*.

(1) Congenital malformations if associated with neurological manifestations and meningocele even if uncomplicated.

(2) Migraine when frequent and incapacitating.

(3) Paralysis or weakness, deformity, discoordination, pain, sensory disturbance, intellectual deficit, disturbances of consciousness, or personality abnormalities regardless of cause which is of such a nature or degree as to preclude the satisfactory performance of military duty.

(4) Tremors, spasmodic torticollis, athetosis or other abnormal movements more than mild.

c. *Neurosyphilis* of any form (general paresis).

*Individuals presenting a documented history of repeated episodes of motion sickness are administratively disqualified for enlistment/induction into the Navy and Marine Corps.

sis, tabes dorsalis, meningovascular syphilis).

★ d. *Paroxysmal convulsive disorders*, disturbances of consciousness, all forms of psychomotor or temporal lobe epilepsy or history thereof except for seizures associated with toxic states or fever during childhood up to the age of 5.

e. *Peripheral nerve disorder*.

(1) Polyneuritis.

(2) Mononeuritis or neuralgia which is chronic or recurrent and of an intensity that is periodically incapacitating.

(3) Neurofibromatosis.

f. *Spontaneous subarachnoid hemorrhage*, verified history of, unless cause has been surgically corrected.

Section XVI. PSYCHOSES, PSYCHONEUROSES, AND PERSONALITY DISORDERS

2-32. Psychoses

The causes for rejection for appointment, enlistment, and induction are—

Psychosis or authenticated history of a psychotic illness other than those of a brief duration associated with a toxic or infectious process.

2-33. Psychoneuroses

The causes for rejection for appointment, enlistment, and induction are—

a. *History of a psychoneurotic reaction* which caused—

(1) Hospitalization.

(2) Prolonged care by a physician.

(3) Loss of time from normal pursuits for repeated periods even if of brief duration, or

(4) Symptoms or behavior of a repeated nature which impaired school or work efficiency.

b. *History of a brief psychoneurotic reaction* or nervous disturbance within the preceding 12 months which was sufficiently severe to require medical attention or absence from work or school for a brief period (maximum of 7 days).

2-34. Personality Disorders

The causes for rejection for appointment, enlistment, and induction are—

a. *Character and behavior disorders*, as evidenced by—

(1) Frequent encounters with law enforcement agencies, or antisocial attitudes or behavior which, while not a cause for administrative rejection, are tangible evidence of an impaired characterological capacity to adapt to the military service.

(2) Overt homosexuality or other forms of sexual deviant practices such as exhibitionism, transvestism, voyeurism, etc.

(3) Chronic alcoholism or alcohol addiction.

(4) Drug addiction.

(5) Drug abuse characterized by—

(a) The evidence of use of any narcotic drug, barbiturate, amphetamine or hallucinogenic substance at time of examination when the use cannot be accounted for as the result of the advice of a recognized health care practitioner.

(b) Use, other than that prescribed by a recognized health care practitioner of any narcotic drug within a 1-year period prior to examination.

(c) The repeated use of any drug or chemical substance, including marijuana, with such frequency that it appears that the examinee has accepted the use of or reliance on these substances as part of his pattern of behavior (see also TB MED 290; NAVMED P-5116; AFP 160-33).

(d) Cases indicating use of marijuana (not habitual use) of experimental

or casual use of other drugs, except as indicated in (b) above, may be waived by competent authority, as established by the respective service, providing there is no history of repeated drug uses and there is evidence of current drug abstinence and the individual is otherwise qualified for service.

(6) Alcohol abuse. The case of rejection for appointment, enlistment and induction is the repeated irresponsible use of alcoholic beverages which leads to misconduct, unacceptable social behavior or impairment of an individual's performance in his place of employment or educational facility, physical or mental health, financial responsibility or personal relationships within 1 year of examination (see also: TB MED 290; NAVMED P-5116; AFP 160-33).

b. *Character and behavior disorders* when it is evident by history and objective examination that the degree of immaturity, instability, personality inadequacy, and dependency will seriously interfere with adjustment in the military service as demonstrated by repeated inability to maintain reasonable adjustment in school, with employers and fellow-workers, and other society groups.

*c. *Other symptomatic immaturity reactions* such as authenticated evidence of enuresis which is habitual or persistent, not due to an organic condition (para 2-15c) occurring beyond early adolescence (age 12 to 14) and stammering or stuttering of such a degree that the individual is normally unable to express himself clearly or to repeat commands.

d. *Specific learning defects* secondary to organic or functional mental disorders.

*Individuals presenting a documented history of sleepwalking persisting into late childhood or early adolescence are administratively disqualified for enlistment/induction into the Navy and Marine Corps.

Section XVII. SKIN AND CELLULAR TISSUES

2-35. Skin and Cellular Tissues

The causes for rejection for appointment, enlistment, and induction are—

- a. *Acne*. Severe, when the face is markedly disfigured, or when extensive involvement of the neck, shoulders, chest, or back would be aggravated by or interfere with the wearing of military equipment.
- b. *Atopic dermatitis*. With active or residual lesions in characteristic areas (face and neck, antecubital and popliteal fossae, occasionally wrists and hands), or documented history thereof.
- c. *Cysts*.
 - (1) *Cysts, other than pilonidal*. Of such a size or location as to interfere with the normal wearing of military equipment.
 - (2) *Cysts, pilonidal*. Pilonidal cysts, if evidenced by the presence of a tumor mass or a discharging sinus.
- d. *Dermatitis factitia*.
- e. *Dermatitis herpetiformis*.
- f. *Eczema*. Any type which is chronic and resistant to treatment.
 - f.1 *Elephantiasis or chronic lymphedema*.
- g. *Epidermolysis bullosa; pemphigus*.
- h. *Fungus infections*, systemic or superficial types: If extensive and not amenable to treatment.
- i. *Furunculosis*. Extensive, recurrent, or chronic.
- j. *Hyperhidrosis* of hands or feet. Chronic or severe.
- k. *Ichthyosis*. Severe.
- l. *Leprosy*. Any type.
- m. *Leukemia cutis mycosis fungoides; Hodgkins' disease*.

n. *Lichen planus*.

o. *Lupus erythematosus* (acute, subacute, or chronic) or any other dermatosis aggravated by sunlight.

p. *Neurofibromatosis* (Von Recklinghausen's disease).

q. *Nevi or vascular tumors*. If extensive, unsightly, or exposed to constant irritation.

r. *Psoriasis* or a verified history thereof.

s. *Radiodermatitis*.

t. *Scars* which are so extensive, deep, or adherent that they may interfere with the wearing of military equipment, or that show a tendency to ulcerate.

u. *Scleroderma*. Diffuse type.

v. *Tuberculosis*. See paragraph 2-38.

w. *Urticaria*. Chronic.

x. *Warts, plantar*, which have materially interfered with the following of a useful vocation in civilian life.

y. *Xanthoma*. If disabling or accompanied by hypercholesterolemia or hyperlipemia.

z. *Any other chronic skin disorder* of a degree or nature which requires frequent outpatient treatment or hospitalization, interferes with the satisfactory performance of duty, or is so disfiguring as to make the individual objectionable in ordinary social relationships.

★ aa. When in the opinion of the examining physician tattoos will significantly limit effective performance of military service the individual will be referred to the AFEES Commander, for final determination of acceptability.

Section XVIII. SPINE, SCAPULAE, RIBS, AND SACROILIAC JOINTS

2-36. Spine and Sacroiliac Joints

(See also para 2-11.)

The causes for rejection for appointment, enlistment, and induction are—

- a. *Arthritis*. See paragraph 2-11a.
- ★ b. *Complaint of disease or injury of the spine or sacroiliac joints* either with or without objective signs which has prevented the individual from successfully following a physically active vocation in civilian life. Substantiation or documentation of the complaint without objective signs is required.
- ★ c. *Deviation or curvature of spine* from normal alignment, structure, or function (scoliosis, kyphosis, or lordosis) if—
 - (1) Mobility and weight-bearing power is poor.
 - (2) More than moderate restriction of normal physical activities is required.
 - (3) Of such a nature as to prevent the individual from following a *physically active vocation* in civilian life.
 - (4) Of a degree which will interfere with the wearing of a uniform or military equipment.
- ★ (5) Symptomatic associated with positive physical finding(s) and demonstrable by X-ray.
- d. *Diseases of the lumbosacral or sacroiliac joints* of a chronic type and obviously associated with pain referred to the lower extremities, muscular spasm, postural deformities and limitation of motion in the lumbar region of the spine.

e. *Granulomatous diseases* either active or healed.

f. *Healed fracture of the spine or pelvic bones* with associated symptoms which have prevented the individual from following a *physically active* vocation in civilian life or which preclude the satisfactory performance of military duty.

g. *Ruptured nucleus pulposus* (herniation of intervertebral disk) or history of operation for this condition.

h. *Spondylolysis or spondylolisthesis* that is symptomatic or is likely to interfere with performance of duty or is likely to require assignment limitations.

2-37. Scapulae, Clavicles, and Ribs

(See para 2-11.)

The causes for rejection for appointment, enlistment, and induction are—

- a. *Fractures*, until well-healed, and until determined that the residuals thereof will not preclude the satisfactory performance of military duty.
- b. *Injury within the preceding 6 weeks*, without fracture, or dislocation, of more than a minor nature.
- c. *Osteomyelitis* of rib, sternum, clavicle, scapula, or vertebra.
- d. *Prominent scapulae* interfering with function or with the wearing of uniform or military equipment.

Section XIX. SYSTEMIC DISEASES AND MISCELLANEOUS CONDITIONS AND DEFECTS

2-38. Systemic Diseases

The causes for rejection for appointment, enlistment, and induction are—

- a. *Dermatomyositis*.
- b. *Lupus erythematosus*, acute, subacute, or chronic.

- c. *Progressive systemic sclerosis*.
- d. *Reiter's disease*.
- e. *Sarcoidosis*.
- f. *Scleroderma*, diffuse type.
- g. *Tuberculosis*.

(1) Active tuberculosis in any form or location or substantiated history of active tuberculosis within the previous 2 years.

(2) Substantiated history of one or more reactivations or relapses of tuberculosis in any form or location or other definite evidence of poor host resistance to the tubercle bacillus.

(3) Residual physical or mental defects from past tuberculosis that would preclude the satisfactory performance of duty.

(4) (Deleted).

2-39. General and Miscellaneous Conditions and Defects

The causes for rejection for appointment, enlistment, and induction are—

a. Allergic manifestations.

(1) Allergic rhinitis (hay fever). See paragraph 2-28.

(2) Asthma. See paragraph 2-26b.

(3) Allergic dermatoses. See paragraph 2-35.

(4) Visceral, abdominal, and cerebral allergy, if severe or not responsive to treatment.

(5) Bona fide history of moderate or severe generalized (as opposed to local) allergic reaction to insect bites or stings. Bona fide history of severe generalized reaction to common foods, e.g., milk, eggs, beef, and pork.

b. Any acute pathological condition, including acute communicable diseases, until recovery has occurred without sequelae.

c. Any deformity which is markedly unsightly or which impairs general functional ability to such an extent as to prevent satisfactory performance of military duty.

d. Chronic metallic poisoning especially beryllium, manganese, and mercury. Undesirable resid-

uals from lead, arsenic, or silver poisoning make the examinee medically unacceptable.

★ e. Cold injury, residuals of (example: frostbite, chilblain, immersion foot, or trench foot), such as deep-seated ache, paresthesia, hyperhidrosis, easily traumatized skin, cyanosis, amputation of any digit, or ankylosis.

f. Positive tests for syphilis with negative *TPI test unless there is a documented history of adequately-treated lues or any of the several conditions which are known to give a false-positive S.T.S. (vaccinia, infectious hepatitis, immunizations, atypical pneumonia, etc.) or unless there has been a reversal to a negative S.T.S. during an appropriate followup period (3 to 6 months).

g. Filariasis; trypanosomiasis; amebiasis; schistosomiasis; uncinariasis (hookworm) associated with anemia, malnutrition, etc., if more than mild, and other similar worm or animal parasitic infestations, including the carrier states thereof.

h. Heat pyrexia (heatstroke, sunstroke, etc.): Documented evidence of predisposition (includes disorders of sweat mechanism and previous serious episode), recurrent episodes requiring medical attention, or residual injury resulting therefrom (especially cardiac, cerebral, hepatic, and renal).

i. Industrial solvent and other chemical intoxication, chronic including carbon bisulfide, trichloroethylene, carbon tetrachloride, and methyl cello-solve.

j. Mycotic infection of internal organs.

k. Myositis or fibrositis; severe, chronic.

l. Residuals of tropical fevers and various parasitic or protozoal infestations which in the opinion of the medical examiner preclude the satisfactory performance of military duty.

Section XX. TUMORS AND MALIGNANT DISEASES

2-40. Benign Tumors.

The causes for rejection for appointment, enlistment, and induction are—

a. Any tumor of the—

(1) Auditory canal, if obstructive.

(2) Eye or orbit, (para 2-12a(6)).

(3) Kidney, bladder, testicle, or penis.

(4) Central nervous system and its men-braneous coverings unless 5 years after surgery and no otherwise disqualifying residuals of

*For Navy, FTA-ABS test.

surgery or of original lesion.

b. *Benign tumors of the abdominal wall* if sufficiently large to interfere with military duty.

c. *Benign tumors of bone* likely to continue to enlarge, be subjected to trauma during military service, or show malignant potential.

d. *Benign tumors of the thyroid* or other structures of the neck, including enlarged lymph nodes, if the enlargement is of such degree as to interfere with the wearing of a uniform or military equipment.

e. *Tongue, benign tumor of*, if it interferes with function.

f. *Breast, thoracic contents, or chest wall*, tumors, of, other than fibromata lipomata, and

inclusion or sebaceous cysts which do not interfere with military duty.

g. *For tumors of the internal or external female genitalia* see paragraph 2-14h.

2-41. Malignant Diseases and Tumors

The causes for rejection for appointment, enlistment, and induction are—

a. *Leukemia*, acute or chronic.

b. *Malignant lymphomata*.

★ c. *Malignant tumor*, except for small early basal cell epitheliomas, at any time, even though surgically removed, confirmed by accepted laboratory procedures.

Section XX!. VENEREAL DISEASES

2-42. Venereal Diseases

In general the finding of acute, uncomplicated venereal disease which can be expected to respond to treatment is not a cause for medical rejection for military service. The causes for rejection for appointment, enlistment, and induction are—

a. *Chronic venereal disease* which has not satisfactorily responded to treatment. The finding of a

positive serologic test for syphilis following the adequate treatment of syphilis is not in itself considered evidence of chronic venereal disease which has not responded to treatment (para 2-39f).

b. *Complications and permanent residuals* of venereal disease if progressive, of such nature as to interfere with the satisfactory performance of duty, or if subject to aggravation by military service.

c. *Neurosyphilis*. See paragraph 2-31c.

APPENDIX II

TABLES OF ACCEPTABLE AUDIOMETRIC HEARING LEVEL

Hearing of all applicants for appointment, enlistment, or induction will be tested by audiometers calibrated to either American Standards Association (ASA), or International Standards Organization (ISO) Standards.

All audiometric tracings or audiometric reading recorded on reports of medical examination or other medical records will be clearly identified "Results ASA-1951" or "Results ISO."

Table I. Acceptable Audiometric Hearing Level for Appointment, Enlistment and Induction

American Standards Association (ASA)		International Standards Organization (ISO)	
Cycles per second (hz)	Both ears	Cycles per second (hz)	Both ears
500	Average of the 6 readings (3 per ear) in the three speech frequencies not greater than twenty (20) decibels with no level greater than twenty-five (25) decibels.	500	Average of the 6 readings (3 per ear) in the speech frequencies not greater than thirty (30) decibels with no level greater than thirty-five (35).
1000		1000	
2000		2000	
4000	50 (each ear)	4000	55 (each ear)

OR

If the average of the three speech frequencies is greater than 20 decibels (ASA) or 30 decibels ISO reevaluate the better ear only in accordance with the following table of acceptability.

	ASA	ISO
500 (hz)	15 decibels	30 decibels
1000 (hz)	15 decibels	25 decibels
2000 (hz)	15 decibels	25 decibels
4000 (hz)	30 decibels	35 decibels

The poorer ear may be totally deaf.

Table IV. Conversion Table. (To convert Individual Audiograms from the American Standards Association (ASA) to International Standards Organization (ISO))

AT	ADD
250 cps	15 db
500 cps	15 db
1000 cps	10 db
2000 cps	10 db
3000 cps	10 db
4000 cps	5 db
6000 cps	10 db
8000 cps	10 db

Identify the results of each audiogram as "ASA" or "ISO."

APPENDIX III

TABLE OF WEIGHT

Table 1. Table of Militarily Acceptable Weight (in Pounds) as Related to Age and Height for Males—Initial Procurement

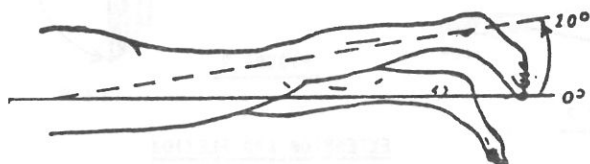
Height (inches)	Minimum (regardless of age)	MAXIMUM				
		16-20 years	21-30 years	31-35 years	36-40 years	41 years and over
60.	100	158	163	162	157	150
61.	102	163	168	167	162	155
62.	103	168	174	173	168	160
63.	104	174	180	178	173	165
64.	105	179	185	184	179	171
65.	106	185	191	190	184	176
66.	107	191	197	196	190	182
67.	111	197	203	202	196	187
68.	115	203	209	208	202	193
69.	119	209	215	214	208	198
70.	123	215	222	220	214	204
71.	127	221	228	227	220	210
72.	131	227	234	233	226	216
73.	135	233	241	240	233	222
74.	139	240	248	246	239	228
75.	143	246	254	253	246	234
76.	147	253	261	260	252	241
77.	151	260	268	266	259	247
78.	153	267	275	273	266	254

APPENDIX IV

JOINT MOTION MEASUREMENT (TM 8-640)

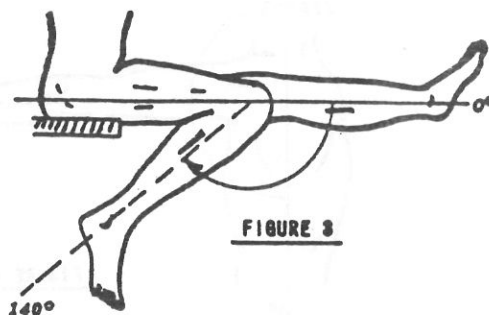
1. THE HIPFIGURE 1FLEXION

- a - POSITION - Supine, knee flexed; opposite knee and hip straight
- b - STATIONARY ARM* - Parallel to long axis of trunk.
- c - MOVING ARM* - In line with lateral midline of femur.

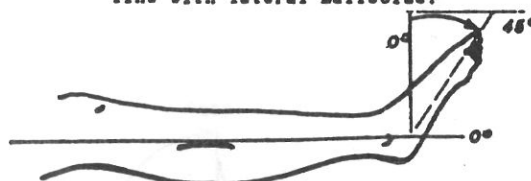
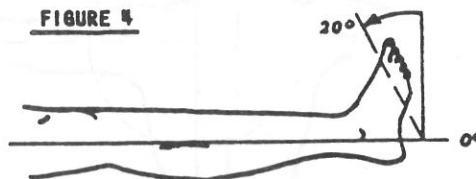
FIGURE 2EXTENSION

- a - POSITION - Prone
- b - STATIONARY ARM* - Parallel to long axis of trunk.
- c - MOVING ARM* - In line with lateral midline of femur.

(*) For purposes of this regulation, stationary arm and moving arm refer to the stationary and moving portions of the goniometer.

2. THE KNEEFIGURE 3EXTENSION AND FLEXION

- a - POSITION - Sitting with knee flexed.
- b - STATIONARY ARM* - Parallel to femur on a line from the lateral condyle to greater trochanter.
- c - MOVING ARM* - Parallel to fibula on line with lateral malleolus.

FIGURE 4FIGURE 5PLANTAR FLEXION & DORSIFLEXION

- a - POSITION - Supine with heel over edge of table and knee extended.
- b - STATIONARY ARM* - Parallel to fibula.
- c - MOVING ARM* - In line with the lateral edge of the heel and the head of the 5th metatarsal.

JOINT MOTION MEASUREMENT - Cont.

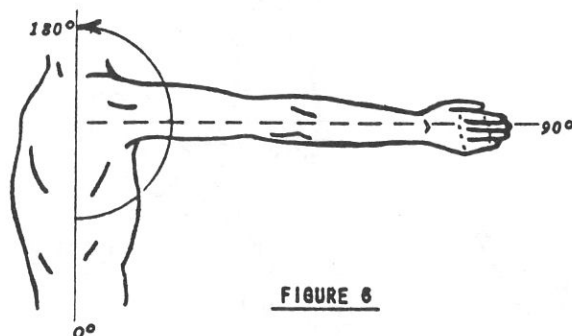
4. THE SHOULDER

FIGURE 6

FLEXION

- a - POSITION - Standing, sitting or supine with elbow extended. Palm facing medially. Measure from lateral aspect of body.
- b - STATIONARY ARM[°] - Along mid-axillary line of trunk.
- c - MOVING ARM[°] - Along lateral midline of humerus.

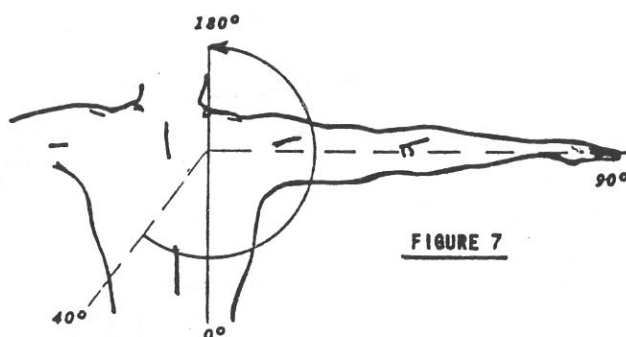


FIGURE 7

ADDUCTION AND ABDUCTION

- a - POSITION - Standing or sitting.
- b - STATIONARY ARM[°] - Parallel to spine but at lateral aspect of body.
- c - MOVING ARM[°] - Parallel to midline of humerus toward olecranon process.

(*) For purposes of this regulation, stationary arm and moving arm refer to the stationary and moving portions of the goniometer.

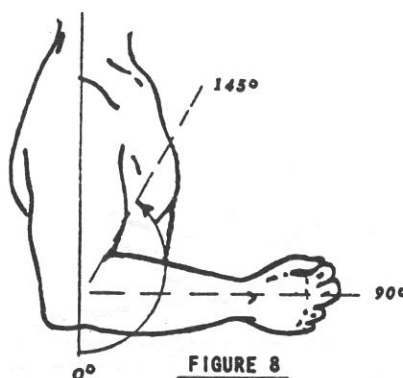
5. THE ELBOW

FIGURE 8

EXTENSION AND FLEXION

- a - POSITION - Standing, sitting or supine. Forearm in mid-position between supination and pronation.
- b - STATIONARY ARM[°] - Along midline of humerus.
- c - MOVING ARM[°] - Along midline of dorsal aspect of forearm.

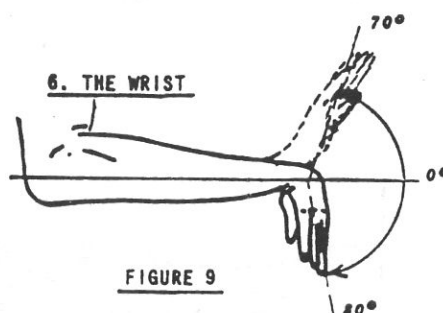


FIGURE 9

EXTENSION AND FLEXION

- a - POSITION - Sitting or standing with elbow flexed and forearm in pronation.
- b - STATIONARY ARM[°] - Along lateral midline of forearm.
- c - MOVING ARM[°] - Parallel to 5th metacarpal.

15-31. Aviation Personnel

- (1) See section V of this chapter.

15-32. Submarine Duty

(1) In view of the special conditions characteristic of the submarine service, all officer and enlisted personnel who are candidates for submarine duty shall conform to the standards set forth herein. Submarine candidates are required to establish their physical fitness for this duty at the time they apply for submarine duty or training. The examinations properly recorded on SF 88 and SF 93, supported by necessary ancillary studies and consultation reports, must be filed in the individual's Health Record. Likewise, on all subsequent special and periodic physical examinations for any purpose, submarine duty shall be included as an additional purpose, and a qualification determination made. Only those examinations finding the individual not physically qualified for submarine duty, but for whom a waiver to the standards appears justified, need be submitted to COMNAVMEDCOM for review. Waivers to the standards will be considered on an individual basis considering risks to the individual and ship's crew and mission, the candidate's training, command endorsements, the examiner's recommendations, and the needs of the service.

(2) Standards for first acceptance into the submarine service are the same as those for initial entry given elsewhere in this chapter as standards for original enlistment (art. 15-30-2) or commission in the naval service (arts. 15-8 through 15-28), except as modified below.

(a) *Abdomen and Gastrointestinal System.* — Individuals with a history of disease such as severe colitis or irritable bowel syndrome, peptic ulcer disease, recurrent or chronic pancreatitis, or chronic diarrhea shall not be qualified unless they have been asymptomatic on an unrestricted diet without medication during the past 2 years and currently have no radiographic or endoscopic evidence of active disease or of severe scarring or deformity. A history of gastrointestinal tract perforation or hemorrhage is absolutely disqualifying until the cause is discovered and corrected; then the above 2 year criteria applies.

(b) *Dental.* — A complete dental examination shall be conducted by a dental officer if available. If a dental officer is not available, the examination shall be conducted by a medical officer. Candidates must have a sufficient number of natural or artificial teeth to ensure satisfactory masticatory and incisal function. Acute infectious disease of the soft tissues of the oral cavity are disqualifying until remedial treatment is completed. Correctable dental caries are in themselves not considered disqualifying for entrance, retention, or transfer within the

submarine service. However, essential dental treatment for moderate or advanced caries shall be completed in time to meet anticipated transfer dates to basic submarine school. Transfer to other submarine training activities or facilities should be in accordance with article 15-57. A candidate who will require dental prosthetic restorations during the period of training should be considered not physically qualified. Malocclusion (crossbite, overjet, or overbite with or without impingement) is not cause for physical disqualification unless it interferes with incisal or masticatory function to such degree that adequate nutrition cannot be obtained from food normally served as a regular diet by a general food service. Missing teeth replaced by satisfactory bridges or dentures shall not be considered disqualifying.

(c) *Ears and Hearing.* —

(1) A thorough otoscopic examination of the auditory canals and tympanic membranes shall be made. Acute or chronic disease of the inner or middle ear or history of surgery with retention of prosthesis shall be disqualifying.

(2) History of chronic inability to equalize pressure manifested by repeated aural barotrauma or persistent ear pain secondary to minor pressure variations (e.g., in aircraft or tunnel) shall be considered disqualifying. In instances where a clinical determination cannot be made, the candidate shall be subjected to a 50 PSIG pressure test in a recompression chamber. Inability to satisfactorily pass this pressure test shall be disqualifying.

(3) All submarine candidates shall meet the same auditory acuity standards as those in 15-11(3). Additionally, submarine ST personnel shall meet the following minimum auditory requirements for each ear:

Cycles (Hz)	500	1000	2000	4000	8000
Decibels (ISO)	35	30	30	40	45

Audiometric testing at 6000 Hz may be substituted when testing at 8000 Hz is impractical. The minimum hearing threshold level (HTL) at 6000 Hz should be 40 db (ISO). When the HTL exceeds 40 db at 6000 Hz, but is within specifications at all other frequencies, the deficit may be disregarded.

(d) *Extremities.* — Candidates with conditions which result in decreased strength or range of motion of such nature to interfere with ready movement about a submarine shall be disqualified. Likewise conditions causing a person to be excessively prone to injury shall be disqualified. Chondromalacia patella or a history thereof within the preceding 2 years shall be considered disqualifying.

(e) *Eyes and Vision.* —

(1) Eyes must be free from acute or chronic diseases or conditions.

(2) The minimum visual acuity for submarine personnel shall be as follows:

(a) *Line Officers.*—Any degree correctable to 100 percent BVE. Spherical equivalent (the algebraic sum of the spherical correction plus one-half of the cylindrical correction) may not exceed plus or minus 5.50 diopters. Cylindrical correction may not exceed plus or minus 2.00 diopters.

(b) *Staff Corps Officers.*—Any degree correctable to 90 percent BVE. Spherical correction may not exceed plus or minus 8.00 diopters. Cylindrical correction may not exceed plus or minus 3.00 diopters.

(c) *Quartermasters and Quartermaster Strikers.*—Any degree correctable to 100 percent BVE. Spherical equivalent may not exceed plus or minus 5.50 diopters. Cylindrical correction may not exceed plus or minus 2.00 diopters.

(d) *Enlisted Personnel (except QM).*—Any degree correctable to 90 percent BVE. Spherical correction may not exceed plus or minus 8.00 diopters. Cylindrical correction may not exceed plus or minus 3.00 diopters.

(3) Normal color perception is required for all submarine candidates except those within SK, YN, MS, and PN ratings. Screening shall be conducted with the Farnsworth Lantern or one of the pseudoisochromatic plate tests if the Lantern is not available. However, if a pseudoisochromatic plate is used in preliminary screenings because of the unavailability of a Lantern, the candidate's failure on the plate test is not sufficient to disqualify. Final disqualification can only be determined using the Lantern as set forth in article 15-97.

(f) *Genitourinary.*—In general a history of urinary calculi shall be disqualifying. Consideration for a waiver for an individual with such a history should include a urologic evaluation sufficient to exclude those who have retained calculi or who can be shown to have a propensity to form additional calculi.

(g) *Lungs and Chest Wall.*—

(1) The results of a current 14 x 17 chest inch (35.46 x 43.18 cm) radiograph shall be recorded as part of the initial submarine duty physical examination. A current radiograph is defined as being within the preceding 6 months. Chest radiographs are not required on nor encouraged for subsequent submarine duty examinations unless otherwise indicated or required.

(2) The following conditions are considered disqualifying for submarine duty: chronic inflammatory disease in any instance where activity can be definitely demonstrated or reasonably assumed such as tuberculosis, sarcoidosis, histoplasmosis, coccidiomycosis, bronchiectasis, or abscess. Isolated tuberculin skin test reaction/conversion shall not be disqualifying; but, the provisions of BUDMEDINST 6224.1 series shall be strictly enforced.

(3) Confirmed history of bronchial asthma after age 12, chronic obstructive pulmonary

disease, a history of pneumothorax within 2 years of the date of examination (1 year if due to simple trauma or surgery), or any history of recurrent spontaneous pneumothorax shall be absolutely disqualifying.

(h) *Mouth, Nose, Pharynx, Trachea, Esophagus, and Larynx.*—In addition to the general provisions given elsewhere in this chapter, special consideration shall be given to conditions which preclude ability to equalize pressure. In instances where a clinical determination cannot be made, the candidate shall be subjected to a 50 PSIG pressure test in a recompression chamber. Inability to satisfactorily pass this pressure test shall be disqualifying.

(i) *Psychoses, Psychoneuroses, and Personality Disorders.*—Because of the nature of the duties and responsibilities of each person in a submarine, the psychological fitness of applicants for submarine training must be carefully appraised. The objective is to elicit evidence of tendencies which militate against satisfactory adjustment to submarine life. Among these are below average intelligence, claustrophobic tendencies, lack of motivation, unhealthy motivation, history of past personal ineffectiveness, difficulties in interpersonal relations, lack of adaptability, or personality disorders. While the above tendencies or conditions are generally grounds to disqualify an individual from initial submarine training or assignment, once an individual is accepted into the submarine service a bonafide psychiatric illness is required to medically disqualify for submarine duty.

(j) *Skin and Cellular Tissues.*—In addition to the general provisions given elsewhere in this chapter, conditions which may be aggravated by the submarine environment are disqualifying. Such conditions include acne vulgaris of moderate or severe degree, a history of psoriasis or eczema, and unexplained or recurrent rashes.

(k) *Spine, Scapulae, Ribs, and Sacroiliac Joints.*—Persistent or recurrent conditions which preclude ready movement in confined spaces, inability to stand and sit for prolonged periods, or lift and carry at least 40 pounds shall be disqualifying.

(l) *Systemic Diseases and Miscellaneous Conditions and Defects.*—Allergic manifestations of such severity as to require allergy immunotherapy (AIT) shall be disqualifying for initial entry into the submarine service. For continuation on submarine duty, however, a member who is well controlled on maintenance AIT may be recommended for waiver if:

(1) Therapy is *not* for stinging insect venom.

(2) No injections are administered aboard a ship which is underway.

(3) No injections are administered without the knowledge and immediate availability of a medical officer.

(4) The member is provided with an AIT kit

and proper storage facilities. In addition to the AIT injection material, the AIT kit should contain as a minimum written instructions including: name of the member, dosage and frequency of maintenance AIT, method of administration and storage, procedures for reinstituting maintenance AIT following various periods of AIT interruption, special precautions and an outline of treatment in event of an adverse reaction to AIT, procurement instructions for replacement AIT injection material, criteria for discontinuation of AIT, and the name, address, and phone number of the physician prescribing AIT.

(3) In general, the standards for continuing of submarine duty shall be the same as for first acceptance for submarine duty.

(a) Submarine personnel reporting for duty following absence due to serious illness or injury or upon return to submarine duty after absence for more than 2 years, shall, at the earliest practicable date have a Health Record review and such physical examination as may be required by an undersea medical officer to determine their physical fitness to resume submarine duty.

(b) Submarine personnel who have developed or are found to have defects normally considered disqualifying should be processed for a waiver provided that: the defects are not of such nature as to preclude the reasonable performance of submarine duties of their grade or rate; the defects would not be exacerbated by submarine duty; or the defects are not detrimental to other members of the crew or the submarine mission.

(c) Submarine personnel who have developed or are found to have disqualifying defects which preclude their ability to reasonably perform the duties of their grade or rate in submarines, or whose duty in submarines would be detrimental to their health, other members of the crew, or to the mission of the submarine, should be processed for submarine disqualification. An undersea medical officer shall make a recommendation in all such processing of submarine physical disqualifications. When an undersea medical officer is not available, the disqualification recommendation shall be forwarded for decision to Commander, Naval Military Personnel Command via the chain of command and, COMNAVMEDCOM (MEDCOM-21).

(4) Since all personnel aboard nuclear submarines are monitored for ionizing radiation, any condition which disqualifies per NAVMED P-5055 precludes assignment to a nuclear submarine. A physical examination for determination for occupational exposure to ionizing radiation, however, is not required solely for submarine duty.

(a) Physical qualification for submarine duty permits a member to serve aboard any submarine.

(b) Those members who are otherwise qualified for submarine duty but disqualified per NAVMED P-5055 may be recommended for waiver designating them for "diesel submarine duty only." If so approved by the Naval Military Personnel Command (NMPC), it then becomes incumbent

upon NMPC to ensure that the individual is never assigned to a position requiring monitoring for ionizing radiation in the line of duty.

15-33. Occupational Exposure to Radiation

(1) Ionizing.—Standards for assignment to duties involving occupational exposure to ionizing radiation are set forth in NAVMED P-5055 and in MANMED for original enlistment or commission in the naval service except as modified below. Waivers to the standards set forth in NAVMED P-5055 are precluded; however, those physical examinations finding an individual disqualified are required to be submitted to COMNAVMEDCOM (MEDCOM-21) and are subject to review by the Radiation Effects Advisory Board. Waivers to standards not specified in NAVMED P-5055, but contained in MANMED shall be evaluated on an individual basis considering: risk to individual or ship's crew and mission, the candidate's training, command endorsements, the examiner's recommendation, and the needs of the service.

(2) Nonionizing.—Standards for assignment to duties involving occupational exposure to nonionizing radiation are the same as for original enlistment or commission in the naval service. The examination performed shall also include those special surveillance items required by NAVMEDCOMINST 6470.2 series (laser) as appropriate.

(3) Continuation of Duty.—The standards for continuation of duties involving occupational exposure to radiation are the same as standards for replacement.

15-34. Nuclear Field

(1) Candidates for nuclear field training must meet the following standards and those in art. 15-33.

(a) Ears and Hearing.—All candidates shall meet the auditory standards in article 15-11(3).

(b) Eyes and Vision.—All candidates must have color vision evaluated by the FALANT. Procedures for conducting and recording the FALANT are in art. 15-97.

(c) Psychoses, Psychoneuroses, and Personality Disorders.—Because of the potential for misuse of devices and sources emitting ionizing radiation, the psychological fitness of applicants must be carefully appraised by the examining physician. Evidence of tendencies which may disqualify an individual are: below average intelligence, unhealthy motivation, a history of irrational behavior or irresponsibility, or a documented personality disorder. While the above tendencies or conditions are generally grounds to disqualify an individual from initial training or assignment, once an individual is accepted, a bonafide psychiatric illness is required to medically disqualify from this special duty.

Note.—There is no article 15-35.

15-36. Diving Duty

(1) All personnel engaged in hyperbaric chamber duty, diving, and underwater swimming, and all candidates for such duty, must conform to the physical standards in this article. Results of medical examination will be recorded on the SF 88 and SF 93 (both will be completed on all initial and periodic diving medical examinations). Every diving medical examination will be filed in the individual's Health Record.

(a) In all cases where diving medical examinations are not personally performed by a qualified Diving or Undersea Medical Officer, a copy of the diving medical examination will be forwarded to COMNAVMEDCOM (MEDCOM-21) for review.

(b) In all cases where a waiver of the physical standards for the continuance of diving duty, or diving training is required, a copy of the diving medical examination will be forwarded to COMNAVMEDCOM (MEDCOM-21) for review.

(c) In all cases where diving medical examinations are personally performed by a qualified Diving or Undersea Medical Officer, in which no disqualifying findings are determined, the examination will not be forwarded to COMNAVMEDCOM (MEDCOM-21) for review. Additionally, such reviews are not required for findings for which waivers of the physical standards have been granted, unless the waived condition has progressed or deteriorated.

(2) Frequency of Diving Medical Examinations.-

(a) Applicants.-A diving medical examination (DME) is required of all candidates.

(b) Officer Personnel.-Officer DME must coincide with requirements for periodic officer examinations, unless superseded by (d), (e), or (f) below.

(c) Enlisted Personnel.-Enlisted DME must be conducted within 3 months of the following birthdays, 18, 21, 24, 27, 30, 32, 34, 36, 38, 40, and yearly thereafter unless superseded by (d), (e), or (f) below.

(d) Saturation Divers.-Yearly DME will be required within 1 month of birthday.

(e) Experimental Divers.-All divers engaged in experimental or research diving must have yearly DME within 1 month of birthday.

(f) All Personnel.-All personnel with sickle cell hemoglobin trait (SCT) and matched control subjects-those personnel identified following BUMEDINST 6260.26 series-must have a yearly DME required within 1 month of their birthday.

(3) Scope.-At the discretion of the examining medical officer, DME may be combined with examinations done for other purposes (e.g., reenlistment, promotion, explosive vehicle driver, parachutist) provided the requirements for a DME are met. The examination must contain at least the following:

(a) SF 88, completed following article 16-38.

(b) SF 93, completed following article 16-42.

(c) Chest roentgenogram (14" (35.46 cm) X 17" (43.18 cm)).

(d) Hemogram.

(e) Urinalysis.

(f) Electrocardiogram. Required on all divers at age 40 and over.

(g) SMA-12 and FBS. Required on all divers at age 40 and over.

(4) Physical Standards.-Any disease or condition that causes chronic or recurrent disability, increases the hazards of isolation, or has the potential of being exacerbated by the hyperbaric environment will be disqualifying at the discretion of the cognizant medical officer. Particular attention must be directed to the following items.

(a) Weight.-The weight standards listed below must apply. If a diver exceeds these standards and the cognizant medical officer feels the increase is due to muscular build and not physical fitness, a recommendation to COMNAVMEDCOM for waiver is appropriate. Such recommendation should include pertinent front and side view photographs. Further, individuals who fall within these weight standards but who present an excess of fatty tissue will be disqualified.

Height in. (cm)	Max weight lbs (kg)	Height in. (cm)	Max weight lbs. (kg)
64(162.56)	164(73.80)	72(182.88)	205(92.25)
65(165.10)	169(76.05)	73(185.42)	211(94.95)
66(167.64)	174(78.30)	74(187.96)	218(98.10)
67(170.18)	179(80.55)	75(190.50)	224(100.80)
68(172.72)	184(82.80)	76(193.04)	230(103.50)
69(175.26)	189(85.05)	77(195.58)	236(106.20)
70(177.80)	194(87.30)	78(198.12)	242(108.90)
71(180.34)	199(89.55)		

(b) Vision.-All divers must correct to 20/20 (100 percent BVE). Combat swimmers must be uncorrected vision no lower than 77 percent BVE; nor will uncorrected vision in either eye be less than 20/70. All other divers will have uncorrected vision no lower than 49 percent BVE; nor will uncorrected vision in either eye be less than 20/200.

(c) Color Vision.-Diving candidates must pass the Farnsworth Lantern Test following article 15-15.

(d) Teeth.-A complete dental examination will be conducted by a dental officer, if available. If a dental officer is not available, the examination will be conducted by a medical officer. Acute infectious diseases of the soft tissues of the oral cavity are disqualifying until remedial treatment is completed. Advanced oral diseases and generally unserviceable teeth will be cause for rejection. Applicants with moderate malocclusion, or extensive restorations and replacements by bridges or dentures, may be accepted, if such do not interfere with effective use of self contained underwater breathing apparatus (SCUBA).

(e) Ears, Nose, and Throat.-The following conditions are disqualifying: acute disease, chronic serous otitis media, perforation of the tympanic membrane, any nasal or pharyngeal respiratory obstruction, chronic sinusitis if not readily controlled, speech impediments due to organic defects, or inability to equalize pressure due to any cause.

(f) *Hearing*.—The auditory standards in article 15-11 shall apply.

(g) *Pulmonary*.—Congenital and acquired defects which may restrict pulmonary function, cause air-trapping, or affect the ventilation-perfusion balance shall disqualify for both initial training and continuation. In general, chronic obstructive or restrictive pulmonary disease of any type shall be disqualifying.

(h) *Hematology*.—Any significant anemia or history of hemolytic disease must be evaluated. Applicants for diving duty shall have a sickle cell test result recorded in their Health Record and on each SF 88 completed for diving duty. Applicants having a positive sickle cell test shall have a quantitative hemoglobin electrophoresis documented in their Health Record, a copy of which shall be appended to the SF 88. All above documentation and previous waivers shall be forwarded to COMNAVMECOM for evaluation of fitness for diving duty.

(i) *Skin*.—Acute or chronic diseases that are exacerbated by the hyperbaric environment are disqualifying.

(j) *Neurologic*.—Organic brain disease seizure disorders of any sort, and head injuries with sequelae shall be disqualifying.

(k) *Musculoskeletal*.—Saturation divers shall have triennial long bone roentgenogram surveys with diving medical examinations.

(l) *Psychiatric*.—The special nature of diving duties requires a careful appraisal of the individual's emotional and temperamental fitness. Personality disorders, neuroses, immaturity, instability, and asocial traits shall disqualify. Stammering or stuttering shall disqualify.

(m) *Age*.—Candidates who have attained the 35th birthday will not be considered for initial diving training without a waiver. All divers 45 years of age or older require a waiver to continue diving. If a waiver is granted the diver is eligible only for senior supervisory capacity. For the purpose of physical qualification, COMNAVMECOM defines diving senior supervisory capacity as essentially passive, non-exertional diving.

(5) *Special Requirements*.—Required only of candidates.

(a) *Ability to Equalize Pressure*.—All candidates shall be subjected in a recompression chamber to a pressure of 50 pounds (20.50 kg) per square inch to determine their ability to withstand the effects of pressure. This test should not be performed in the presence of a respiratory infection that may temporarily impair the ability to equalize or ventilate.

(b) *Oxygen Tolerance*.—Individual susceptibility to oxygen shall be tested by determining candidate's ability to breathe oxygen without deleterious effects at a pressure of 27 pounds (60 feet) (12.15 kg (18 meters)) for a period of 30 minutes.

(6) *Hazardous Divers*.—Cognizant Medical Department personnel shall assure that divers are physically capable of diving prior to their initial dive each day. Divers shall ordinarily be examined prior to each unusually hazardous or extensive dive.

(7) *Waiver of the Physical Standards*.—When an individual is disqualified as not meeting the physical standards, and when the cognizant medical officer feels the defect neither places the individual at undue risk nor interferes with the performance of diving duties, a recommendation for waiver of the physical standards shall be made according to the procedure outlined in article 15-44.

15-37. Antarctic—"Operation DEEP FREEZE"

(1) *Purpose*.—The purpose of this examination is to identify civilian employees, visitors, and military personnel who are physically qualified and temperamentally adapted for assignment or travel to any antarctic research or support station, and to disqualify those individuals who may require repeated, prolonged, or specialized medical treatment. In addition to the civilian and military working in support of the U.S. Antarctic Research Program (USARP), there may be U.S. and foreign national visitors sponsored by the National Science Foundation or other agencies who must also meet the criteria outlined by this article before they can be medically approved to visit Antarctica. Medical facilities in Antarctica are limited, and may be quite distant from working or research sites. Depending on the station, assignment may involve complete isolation of up to 9 months in a group numbering from 4 to 60 members. Personnel may be working at terrestrial elevations as high as 12,000 feet (3,600 meters) at temperatures as low as -123 degrees F (-86 degrees C). Although every effort is made to provide comfortable, safe, and pleasant living conditions, the nature of the antarctic environment with its potential hazards and extreme remoteness from major medical facilities make stringent medical and surgical history and physical examination screening mandatory to ensure freedom from any disability which might imperil health, restrict activity, or create a burden for one's associates. There are two assignment categories:

(a) Summer support and research personnel, who are in the Antarctic only during the austral summer (September-February).

(b) Winter-over personnel, whose support of research must be continued through the austral winter (March-August) when the continent is inaccessible and evacuation impossible. Unless otherwise indicated, the following examination procedures shall apply to both categories of personnel.

(2) *Scope of the Examination*.—In each instance, the history-taking, physical examination, and indicated laboratory data shall be sufficiently thorough to allow evaluation of:

(a) Any symptoms of current or significant past illness.

(b) Any genetic diathesis for an anatomic, metabolic, or functional disease.

(c) Any disease requiring chronic maintenance medication which would be exacerbated if the medication were unavailable.

(d) Incipient disease or functional impairment.

(e) Use or abuse of any drug, used therapeutically or whimsically, including alcoholic beverages.

(3) *Report of Medical History.*—To this end, all military and civilian personnel assigned to or visiting the Antarctic shall complete an SF 93, Report of Medical History, or equivalent, which then shall be reviewed by the examiner and all positive answers commented upon appropriately, avoiding the use of such phrases as "history reviewed and considered NCD," or similar vague statements. In general, any recent history of severe illness requiring prolonged followup is disqualifying. Recovery from major surgical procedures, usually 6 months, must be complete before leaving for the Antarctic. Absence of significant physical impairment will be the major determining factor for qualification for deployment below 60 degrees South and Antarctic continent.

(4) *General Physical Examination.*—All candidates for antarctic assignment shall undergo a complete medical examination initially and annually prior to each deployment. The examination shall be reported on SF 88, or civilian equivalent approved by FMO and CNSFA, with special attention to the following items:

(a) *Age.*—There shall be no age limitations, provided the candidate is otherwise fit for antarctic assignment, has no functional impairment, and meets all other health criteria herein established.

(b) *ENT.*—

(1) Frequent epistaxis shall be evaluated and its causes treated before antarctic assignment is approved. Recurrent or unresolved epistaxis shall be disqualifying.

(2) The paucity of antigenic stimuli in Antarctica provides a relatively ideal environment for the allergic individual; any candidate taking desensitization injections must obtain the advice of the allergist to determine if the desensitization regimen may be discontinued while in the Antarctic. This hiatus in desensitization therapy must be voluntary on the part of the individual and only upon the advice of the individual's allergist. Desensitization injections shall be disqualifying for winter—over or outlying station personnel.

(c) *Pulmonary System.*—

(1) Working in extreme cold or at high terrestrial elevations may compromise oxygenation in even the most robust individual. Hence, chronic obstructive pulmonary disease, diagnosed by X-ray or pulmonary function test, of any etiology shall

be considered disqualifying. Objective assessment of pulmonary status should be obtained by appropriate pulmonary function testing in candidates where a question of pulmonary disease exists.

(2) Acute bronchopulmonary infection shall be disqualifying until resolved. Recurrent bronchitis or bronchospastic disease shall be disqualifying.

(3) Repeated pulmonary embolism or recurrent spontaneous pneumothorax shall be disqualifying.

(d) *Cardiovascular System.*—In addition to careful external examination of the heart and heart sounds, a standard 12-lead electrocardiogram is required as a baseline on the initial examination for all personnel and annually after the age of 40. Stress electrocardiography is strongly recommended for applicants over 40 years of age, on those with any question of their cardiac status.

(1) Angina pectoris or recurrent myocardial infection shall be disqualifying.

(2) Hypertensive cardiovascular disease shall be disqualifying. See paragraph (p) below.

(3) Valvular heart disease of any etiology shall be disqualifying.

(4) Paroxysmal dysrhythmias, e.g., paroxysmal atrial tachycardia, and conduction abnormalities reflecting underlying heart disease shall be disqualifying.

(e) *Gastrointestinal.*—

(1) Chronic or active peptic ulcer disease, diverticulitis, regional enteritis, or any chronic inflammatory bowel disease shall be disqualifying.

(2) Symptomatic chronic or recurrent biliary tract disease or pancreatitis shall be disqualifying.

(3) Unrepaired inguinal, umbilical, or femoral hernias shall be disqualifying.

(4) Frequently or severely symptomatic hemorrhoids must be repaired.

(f) *Endocrine System.*—

(1) The results of a 3-hour glucose tolerance test shall be submitted whenever there is history of diabetes mellitus in a parent, sibling, or more than one grandparent; an abnormal glucose tolerance curve shall be disqualifying.

(2) Other endocrinopathy requiring close monitoring and adjustment of exogenously administered hormones shall be considered disqualifying.

(g) *Genitourinary System.*—

(1) Verified, recurrent renal calculi shall be disqualifying.

(2) Chronic or acute pyelonephritis or glomerulonephritis shall be disqualifying.

(h) *Musculoskeletal System.*—

(1) Chronic or frequently recurring lumbosacral pain or unresolved back injury shall be disqualifying.

(2) Instability of the knee or ankle and post-traumatic or postsurgical arthralgia or ankylosis of

the hip, knee, or ankle shall be considered disqualifying; recurrent dislocation of the shoulder shall be disqualifying. If there is uncertainty as to the degree of functional impairment of an involved joint, orthopedic consultation shall be obtained, keeping in mind the high incidence of orthopedic injuries sustained as a result of icy or rocky terrain remote from medical facilities.

(3) Persons with metallic orthopedic devices such as pins, nails, or plates should be carefully evaluated. Pain upon exposure to cold often occurs.

(i) *Skin and Cellular Tissue.*—Exposed skin surfaces are subject to extreme cold and dryness; depending on the Antarctic station assignment, bathing may be limited to once weekly or even less frequently. Woolen garments, including gloves, scarves, and balaclavas, may induce dermatitis in sensitive individuals. With these facts in mind, the following conditions shall be disqualifying unless dermatologic consultation determines that the disorder will not be exacerbated by the conditions enumerated above:

(1) Significant psoriasis requiring ongoing treatment.

(2) Chronic dermatoses requiring treatment.

(3) Acne requiring other than simple medications and local skin care. Exacerbation often occurs under Antarctic conditions.

(4) Any other dermatologic condition which tends to compromise the cutaneous circulation or sensation.

(j) *Neurological.*—The following shall be disqualifying:

(1) Peripheral neuropathy, especially hypesthesia of face or extremities.

(2) Seizure disorder.

(3) Vascular headaches which are poorly controlled or require other than simple medications.

(k) *Psychiatric.*—

(1) Candidates with history or manifestations of psychoses, permanent brain syndromes, significant neuroses or psychophysiologic disorders, and personality disorders shall be disqualified.

(2) Subjects without formal psychiatric diagnosis who nevertheless have experienced chronically or intermittently conflictual relationships, intolerance for environmental stress, a pattern of marginal occupational performance, injudicious consumption of alcohol or other intoxicant substances, sexual maturation or similar identifiable potentials for psychosocial maladaptation should be disqualified. A psychiatric evaluation may be required in questionable situations. Recovering alcoholics requiring continued professional treatment should be disqualified. A minimum of 1 year of sobriety without treatment is recommended. Psychological assessment and psychiatric examination teams are appointed by the Naval Medical Command to determine the emotional fitness of all civilians and military candidates selected to winter-over. To facilitate psychological assess-

ment and psychiatric examination of candidates an assignment questionnaire and evaluation forms have been developed.

(a) Antarctic Assignment Questionnaire, NAVMED 6520/8, shall be presented to each wintering-over candidate and shall be completed, dated, and signed by the candidate and reviewed by a psychiatrist and clinical psychologist as part of their evaluation.

(b) Psychiatric Evaluation Form, NAVMED 6520/9 and Psychological Evaluation Form, NAVMED 6520/10 shall be completed by the psychiatrist and clinical psychologist separately, immediately following the interview of the candidate.

(c) Combined Evaluation Form, NAVMED 6520/11 shall be completed jointly by the psychiatrist and clinical psychologist.

(d) The completed questionnaire and individual forms shall become a permanent part of the candidate's assessment and evaluation record maintained by Naval Medical Command, Washington, DC. NAVMED 6520/8 through 6520/11 are maintained by and available from Medical Department, Naval Support Force, Antarctica, Port Hueneme, CA.

(l) *Gynecologic.*—There is limited gynecologic capability in the Antarctic. All women selected for Antarctic assignment shall submit the results of a PAP smear, bimanual pelvic examination, and breast examination performed within the preceding 6 months. Significant dysmenorrhea or menorrhagia shall be disqualifying. Pregnancy shall be disqualifying.

(m) *Dental Examination.*—All personnel shall have a Type II examination (which includes bite-wing X-rays) and a periodontal examination. Candidates shall be in Class 1 dental condition; i.e., any individual with nonrestored teeth or with periodontal disease shall be disqualified (see art. 6-101). All symptomatic, and potentially symptomatic, third molar teeth not salvageable by other forms of therapy should be extracted and healing completed before leaving for the Antarctic. A waiver for third molar may be requested for short term summer support personnel.

(n) *Laboratory and Radiological Examinations.*—Except as indicated the following examinations are mandatory and must be included with physical examination:

(1) Routine urinalysis to include chemical analysis (glucose and protein) and microscopic examination.

(2) VDRL, RPR, or other suitable test for syphilis.

(3) Blood type and Rh factor. First examination only.

(4) A complete blood count to include total white cell count, hematocrit, hemoglobin, and platelet estimate. Individuals with a family history of hemoglobinopathy must have a hemoglobin electrophoresis performed.

(5) Winter—over personnel shall have a blood bank group, type and panel cell studies performed during their physical examination.

(6) EKG (see subparagraph (4)(d) above).

(7) All personnel must have a 14 X 17 inch (35.46 X 43.18 cm) PA chest X-ray within 6 months prior to the initial Deep Freeze examination. This shall be repeated every 5 years until age 45 and annually thereafter. Chest X-rays will be otherwise requested based upon clinical indication.

(8) Any additional laboratory tests that may be indicated by the medical history or physical examination (e.g., renal function tests, liver function tests, cholesterol/triglycerides, etc.).

(o) *Body Weight and Build.*—Obesity compromises stamina and endurance, thus diminishing performance and imperiling health. It is the responsibility of the examining physician to determine whether a candidate is overweight, according to height, general physical condition, and appearance. A waist measurement at the umbilicus is required. An individual determined thusly to be obese and overweight shall be disqualified.

(p) *Blood Pressure Measurement.*—Candidates whose sitting and recumbent blood pressures are persistently above 140/90 must be appropriately evaluated and treated by the examining physician or medical facility. Any individuals with hypertension shall list all medication which they must take. If the hypertension is not adequately controlled by simple antihypertensive (2-day therapy) regimen and patient cooperation, the individual shall be disqualified. Any individual with evidence of progressive or severe target organ disease secondary to hypertension shall be disqualified.

(q) *Visual Acuity.*—Vision should be correctable to 20/20 in each eye. For candidates requiring corrective lenses, the lens prescription must be in the Health Record. Two pairs of standard lenses are required. All personnel shall have a pair of sunglasses which should be worn when working outside in the Antarctic. Candidates over 40 should have their intraocular pressure measured and recorded on the physical examination.

(r) *Hearing.*—If practicable, an audiogram should be recorded. When audiometry is not available, the whispered voice test shall be performed. An acuity of 15/15 whispered voice in each ear is qualifying. Significant bilateral hearing loss shall be evaluated by an ENT specialist.

(5) *Previous Antarctic Assignment.*—Notation shall be made on the physical exam form regarding any candidate's previous Antarctic experience. This information should include the name of the station to which assigned and a description of any health problems encountered during that assignment.

(6) *Reporting of Physician Examination.*—

(a) *Military Candidates.*—Personnel shall undergo a complete examination in accordance

with this article only after being selected for, and ordered to Naval Support Force, Antarctica ("Operation DEEP FREEZE"), and prior to actual transfer. A completed original SF 88 and SF 93, along with any indicated consultations, shall be submitted for final approval to the Force Medical Officer, Commander, U.S. Naval Support Force, Antarctica, FPO San Francisco 96601, prior to actual transfer of selectee from originating duty station.

(b) *Civilian Candidates.*—Civilian personnel selected for the U.S. Antarctic Research Program shall receive a physical examination in accordance with this article at designated naval medical facilities or by a private physician. Physical examination findings not conforming to the provisions of this article shall be submitted with appropriate waiver requests and any indicated consultations, for final approval to the Force Medical Officer, Commander, U.S. Naval Support Force, Antarctica, FPO San Francisco 96601. This approval must be obtained via the NSF contractor representative before leaving the contiguous U.S.

(c) *Returning Summer Personnel.*—Returning summer support personnel will have the examination at their designated medical facility with the results forwarded as in (a) and (b).

(d) *Winter—over Personnel, Civilian and Military.*—All candidates for winter—over shall receive a complete physical exam as outlined above, and in addition a psychiatric evaluation will be conducted at designated naval medical facilities. Candidates will be notified individually of the date and location of this evaluation. The psychologic test forms and the results of the psychological assessment, psychiatric examination, and combined evaluation shall be forwarded directly to FMO, Commander, U.S. Naval Support Force, Antarctica, FPO San Francisco 96601.

(7) *Procedure for Recommending Waiver.*—All defects shall be noted and recorded on the physical exam forms. If the defect is considered to be disqualifying in accordance with this article, but in the opinion of the medical examiner the candidate would be able to complete the assignment without personal peril or peril to associates, then appropriate specialty consultations and recommendation for waiver of the physical standards involved should be submitted to the Force Medical Officer, Commander, U.S. Naval Support Force, Antarctica, FPO San Francisco 96601. The force medical officer shall take into consideration the candidate's status as summer support/winter—over when waiving any physical standard. Likewise any physical defect or disease process, even though not specifically mentioned in this article but considered to be a liability to the candidate or the mission, shall be disqualifying.

15-38. Marine Security Guard Duty and Other State Department Assignments

(1) Purpose.—To assure that members assigned to duty with the State Department are in all respects physically and dentally qualified for such assignments; and that all necessary medical and dental treatment is accomplished before transfer to such duty since Armed Forces medical facilities at most places of duty with the State Department are limited.

(2) Scope of Examination.—The examination must be sufficiently thorough to ascertain, with reasonable certainty, that the member is free of incipient disease or functional impairment. At a minimum this examination must include:

(a) Detailed medical history to elicit relevant information (including drugs and alcohol abuse or dependency) and afford evaluation of any symptoms, illness or previous entry suggestive of present or incipient disease.

(b) Complete physical examination.

(c) Complete urinalysis and blood count (CBC).

(d) HIV (HTLV-III) test and serologic test for syphilis.

(e) Chest x-ray (14 x 17 inch (35.46 x 43.18 cm)), if clinically indicated.

(f) Mental health evaluation—preliminary psychological screening must be conducted locally before departure for formal training and indoctrination. An unfavorable or questionable report of preliminary psychological examination should be brought to the immediate attention of the member's commanding officer. When assigned to Marine Security Guard Battalion, members will be evaluated by psychological screening to assure suitability for position of high

responsibility and stress in an isolated, small group setting. This evaluation will be performed by officers of the Medical Department specifically trained to conduct such an evaluation.

(g) Dental examination should be followed by correction of noted deficiencies before departure for formal training and indoctrination.

(3) Evaluation.—A member must be physically fit to reasonably perform all the duties of grade or rate in an isolated area where day-to-day medical and dental support is not readily available.

(4) Reporting Procedures.—Record the results of examination (identified as "State Department Physical Examination") on Report of Medical Examination (SF-88) filed in the member's Health Record with appropriate entry in the Chronological Record of Medical Care (SF-600).

15-39. Special Duty, Intelligence Officers (163x Designator)

(1) All candidates must meet the physical standards for restricted line officer and staff corps with the following modifications:

(a) Unaided distant visual acuity must be consistent with the ability to perform duties required and if less than 100% BVE must be correctable to 100% BVE.

(b) Candidates must pass the Farnsworth Lantern Test for color vision following article 15-15.

(c) Normal depth perception and stereoscopic vision with or without corrective lenses is required.

Note: There is no art. 15-40.

Completed a study of the
history of the judicial
system in the United States
and the various changes
which have taken place
in the organization of
the courts and the
methods of selecting
judges. The study was
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15-41. Firefighting Instructor Personnel

(1) *Purpose.*—To assure that members assigned duty as firefighting instructors and exposed to smoke and its associated constituents are in all respects physically qualified for such assignment.

(2) *Systems Standards, Special Considerations.*—All personnel shall meet the physical criteria required for retention in naval service. Acute conditions of a temporary nature are disqualifying until corrected. Special attention shall be given the following conditions which may preclude duty as a firefighting instructor:

(a) *Eyes and Vision.*—

(1) Absence of recurrent, acute and chronic eye disease is required.

(2) Uncorrected vision must be at least 20/80, Snellen, in one eye and at least 20/100, Snellen, in the other.

(3) Near vision, with glasses, must be sufficient to read printed material of Jaeger Number 4 size type without apparent difficulty.

(b) *Ears and Hearing.*—Recurrent, acute or chronic diseases of the external, middle, or internal ear must be absent.

(c) *Nose, Mouth, and Throat.*—

(1) Conditions interfering with distinct speech or with free breathing required in using breathing apparatus are disqualifying.

(2) Evidence of sinus disease requires an ENT consultation and statement which recommends disposition as regards repeated exposure to smoke.

(d) *Lungs.*—

(1) A history of pulmonary tuberculosis with more than moderate involvement and arrested or healed for less than 2 years is disqualifying.

(2) A history of respiratory tract allergic response is disqualifying.

(3) Acute or chronic pleurisy, bronchitis, asthma, emphysema, pneumothorax, bronchiectasis, or other irremediable conditions of the lungs, pleura, or mediastinum are disqualifying.

(e) *Heart and Blood Vessels.*—Disqualifying conditions are: Organic heart diseases; cardiac enlargement; history of angina pectoris; persistent pulse rate at rest exceeding 110 pulses per minute or less than 40 pulses per minute; cardiac arrhythmia or irregularity other than sinus arrhythmia; arteriosclerosis disproportionate to age; and sitting blood pressure reading exceeding 160 mm Hg, systolic, or 90 mm Hg, diastolic. If the initial blood pressure reading exceeds 160 mm Hg, systolic, or 90 mm Hg, diastolic, serial blood pressures will be taken and the average obtained will be the value to be considered.

(f) *Abdomen.*—

(1) Disqualifying conditions are: Acute or chronic disease of the abdominal viscera and significant enlargement of the liver or spleen.

(2) Hernia, of any type except a small umbilical, is disqualifying until satisfactorily repaired.

(g) *Genitourinary.*—Disqualifying conditions are: Acute or chronic genitourinary disease including venereal; acute or chronic prostatitis; large or painful varicocele or hydrocele until satisfactorily repaired.

(h) *Spine, Pelvis, Sacroiliac, and Lumbosacral Joints.*—

(1) Applicants must have free mobility of the spine and pelvic joints.

(2) Disqualifying conditions are: Significant curvature or deformity of the spine which is symptomatic or interferes with physical activity; history of herniated nucleus pulposus with or without surgery.

(3) History of low back pain, sciatica, arthritis or suggested pathology may be disqualifying.

(i) *Extremities.*—Disqualifying conditions are: Ununited fractures and nonreducible dislocations or united fractures and reduced dislocations with incomplete restoration of function; amputation of arm, hand, leg, or foot; loss of any portion of the thumb on either hand; loss of more than a distal phalanx of the index or middle finger of either hand; ankylosed joints; varicose veins other than mild in degree; loss or deformity of great toe or any condition which interferes with function or will prevent performance of arduous activity.

(j) *Emotional and Nervous System.*—

(1) Applicant must be emotionally stable.

(2) Disqualifying conditions are: Epilepsy; chronic alcoholism or drug abuse; and paralysis or paresis.

(k) *Skin.*—

(1) Contact allergies of the skin that involve substances associated with firefighting are disqualifying.

(2) Skin conditions and facial contours which interfere with physical activity and the use of personal protective equipment are disqualifying.

(l) *Blood and Blood-Forming Tissues.*—Disqualifying conditions include: Anemia, iron deficient, hemolytic and myelophthisic; abnormal RBC destruction; abnormal RBC construction (thalassemia and sickle cell), polycythemia vera; leukopenia, chronic or recurrent; thromboembolic disease.

(m) *Endocrine and Metabolic.*—Disqualifying conditions include: Diabetes mellitus; diabetes insipidus; adrenal gland malfunction; acromegaly, thyrotoxicosis, or hypothyroidism; hyperinsulinism; hyper or hypoparathyroidism.

(n) *Other Defects.*—History of more than one episode of diminished heat adaptation capability of any other serious deviation from sound physical condition is grounds for disqualification until corrected, if correctable.

(3) *Reporting Procedures.*—

(a) Record the results of medical examination on SF 88 and SF 93 and enter into the member's

Health Record. For personnel found physically qualified to assume duty as a firefighting instructor, the following data shall be included: Standard P.A. chest X-ray, if clinically indicated; audiogram; vision screening pulmonary function testing (i.e., VC, FVC, and FEV₁); EKG, CBC (i.e., differential white blood cell, hemoglobin, and hematocrit); urinalysis (i.e., albumin, sugar, and microscopic); liver function profile; and an exercise EKG, such as the Master's

two-step, for personnel 35 years of age and older. Appropriate entries shall be made on NAVMED 6150/2, Special Duty Medical Abstract.

(b) The full name and social security number of members found physically qualified for duty as firefighting instructors will be forwarded to BUMED (MED 31422). Similar notification is required upon removal from duty as a firefighting instructor and reassignment to other duties.

Section III. PHYSICAL DEFECTS AND WAIVER

	Article
Physical Defects	15-42
Relative Significance of Physical Defects	15-43
Procedure for Recommending Waiver	15-44

15-42. Physical Defects

(1) The term "physical defect" is intended to include all defects, disorders, disabilities, or conditions which may be of significance in determining an applicant's physical fitness to perform the duties of the grade or rating.

(2) When applicants are accepted, all physical defects which have been noted shall be recorded. Each defect shall be recorded in sufficient detail to show clearly its character, degree, and significance.

(3) When an applicant is rejected, the cause or causes must be clearly established and so recorded as to be conclusive regarding the propriety of the rejection. Symptoms of disease are not to be noted as cause of rejection if it is possible to arrive at a definite diagnosis.

(4) A number of physical defects are listed under specific system headings as causes for rejection. Such defects should ordinarily be considered disqualifying unless a waiver is approved. The various lists of defects are not all inclusive and are not intended to be; they contain most of the more frequently recurring causes of unfitness for performance of duties and indicate the type of defects which are to be considered disqualifying.

15-43. Relative Significance of Physical Defects

(1) *Waiver Not Required.*—When the examiner, after evaluating a defect in accordance with the standards in this chapter, considers it to be of little present or future significance and not to be disqualifying, the examiner need only record and describe the defect on the report of physical examination.

(2) *Waiver Required.*—When a defect is considered to be disqualifying in accordance with the standards, but is of such nature as not to preclude the performance of duty, a waiver may be recommended.

(3) *Waiver Not Appropriate.*—When a defect might constitute a menace to or jeopardize the health, general welfare, or safety of the individual's associates, or of such nature that the individual could not reasonably fulfill the purpose of employment, a waiver is not considered appropriate.

15-44. Procedure for Recommending Waiver

(1) When, in the opinion of the medical or dental examiner and the commanding officer or officer in charge of the examining facility, a waiver of the physical standards is warranted, a recommendation to this effect may be submitted on the Standard Form 88 for consideration for the following:

(a) Appointment or reappointment of an officer in the Navy, Marine Corps, or Naval or Marine Corps Reserve.

(b) Enlistment or reenlistment of a member in the Navy, Marine Corps, or Naval or Marine Corps Reserve. (Also see art. 15-3(3).)

(2) The recommendation for waiver of the physical or dental standards shall include the defects to which referable and shall be entered on the reverse of the SF 88. In addition, the words **WAIVER RECOMMENDED** shall be stamped, printed, or typed in bold type on the upper right margin above item 3 of the SF 88. The commanding officer or officer in charge of the examining facility may indicate on the reverse of the SF 88 approval or disapproval of the findings of the medical examiner. A facsimile stamp may be used for this purpose. Final action on all recommendations for waiver of the physical standards is taken by COMNAVMILPERSCOM or CMC, as appropriate, upon the recommendation of BUMED. Until such ultimate findings are made known to the examining facility, no change in an examinee's status will be accomplished. Applicants may not be processed for shipment until a written waiver has been received from the appropriate waiver authority and made part of the permanent Health Record.

(3) In instances of a physical examination incident to assignment of a naval or Marine Corps reservist to active duty including active duty for training in excess of 30 days, but excluding active duty for training of 30 days or less and involuntary training duty of 45 days, the commanding officer or officer in charge is authorized, upon the recommendation of the medical examiner, to grant a conditional waiver of the physical standards for any defects which in all probability will not interfere with the member's performance on the active list. The conditional waiver carries with it the authority to consider the member physically qualified for active duty, including active duty for training in excess of

30 days, prior to final review of the records in the Navy Department. When granted, the member shall be so advised and the conditional waiver shall be reported on the reverse of the SF 88. The reporting procedure is identical to that applicable to a recommendation for waiver.

(4) The circumstances under which a recommendation for waiver of the physical standards may be submitted are to be distinguished from those pertaining to a conditional waiver in that a recom-

mendation for waiver is applicable to a candidate for appointment, enlistment, or reenlistment in any status, whereas a conditional waiver is to be considered only on an individual who is already a member of the Naval or Marine Corps Reserve, and who has been examined incident to assignment to active duty including active duty for training in excess of 30 days and found not to meet the current physical standards.

Section IV. PHYSICAL EXAMINATIONS

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15-45. General

(1) Physical examinations, unless otherwise provided for, shall be conducted by officers of the Navy Medical Corps, except that dental examinations shall be conducted by officers of the Navy Dental Corps if available. The naval examination officers, unless otherwise provided for, shall sign original entries on reports of such examinations. Medical examiners, regardless of their clinical specialties, shall be familiar with the physical standards pertaining to naval personnel.

(2) The applicant or candidate shall be questioned carefully about past and present physical condition, especially with regard to any serious illness, injury, or operation the applicant may have had. Reference to the completed Standard Form 93 will materially assist the examiner in developing the medical history. All examiners are enjoined to exercise the greatest care in conducting a physical examination and shall assure themselves that all findings are fully and accurately recorded. In doubtful situations, medical examiners should employ any additional available diagnostic procedure which is indicated in an effort to determine the true physical status of the person being examined. In reporting the results of the examination on Standard Form

88 or Standard Form 600, whichever is appropriate, all reports of special examinations shall be included or appended irrespective of whether or not the reports indicate the presence or absence of disease or abnormality.

(3) All physical examinations shall be conducted with due regard to privacy. Furthermore, physical examinations shall be conducted in the presence of a third person if considered advisable.

15-46. Enlistment or Reenlistment

(1) Enlistment.—The physical examination of applicants for enlistment in the Navy or Marine Corps, Regular or Reserve, shall be made by Navy medical and dental officers, if available; otherwise, by medical and dental officers of the Department of the Army or Air Force, or by civilian physicians when authorized by COMNAVMIIPERSCOM, or CMC, as appropriate, upon the recommendation of COMNAVMECOM. Except for members on active duty who are applicants for extension of enlistment or for reenlistment, civilian physicians may be used only on a no-cost-to-the-Navy basis. The results of the examination shall be recorded in the Health Record. Applicants unfit for service by reason of a defect or disability not of

a serious nature and which can be corrected or cured within a short time may be advised to seek treatment with a view to enlistment upon correction or recovery; however, no promise or assurance shall be made to such applicants that they will thereafter be accepted. When applicants are accepted, all physical abnormalities shall be recorded. No applicant shall be accepted for enlistment, except as provided in article 15-3, who does not conform to the standards. The applications of persons desiring to reenlist who have defects or disabilities which would be cause for rejection for original enlistment, but not such as to prevent the performance of the duties to be expected of them, shall be referred to COMNAVMILPERSCOM or CMC via COMNAVMEDCOM, with appropriate recommendation regarding waiver (art. 15-44).

(2) Reenlistment.—This pertains to an enlistment in the Navy or in the Marine Corps of a person who has had prior service in the Navy or in the Marine Corps, respectively. Enlistment in either the Navy or Marine Corps, of a person without such prior service, subsequent to service in any other branch of the Armed Forces does not constitute reenlistment. The physical examination shall conform to all requirements described for officers in article 15-52(4). Attention is directed to article 15-67 for applicable aviation personnel. The physical examination shall be conducted as for original enlistment, but where medical officers of the Department of Defense are not readily available, a waiver of the physical examination is authorized for reenlistment within 24 hours following discharge, provided there is no evidence in the member's Health Record of recent illness or injury and provided further that such reenlistment is in the same Regular or Reserve status. However, physical examination by a Department of Defense medical officer shall be obtained at the earliest opportunity. Appropriate notation shall be made in the member's Health Record to ensure that the requirement for physical examination is not overlooked.

15-47. Recruit Screening Examinations

(1) Purpose.—To detect physical or mental defects or active communicable and infectious disease processes which may have been concealed or were not detected at the time of enlistment or induction; and to ensure that certain laboratory tests, chest x-rays, or other indicated tests are accomplished in instances where facilities were not available at the original examining activity.

(2) When Conducted.—The screening examinations shall be conducted within 10

working days of reporting to the naval training center or Marine Corps recruit depot, as applicable.

(3) Scope of Examination.—All recruits, including reservists reporting for accelerated recruit training, shall undergo a screening examination upon reporting to the training center or recruit depot. The examination shall be sufficiently thorough to ensure that the recruit is free from communicable and infectious diseases and physically fit to undergo military training. Such diagnostic, consultant, or hospitalization procedures as may be indicated shall be used. However, hospitalization shall only be effected when actually necessary for evaluation of a significant abnormality. If not previously reported, x-ray of the chest, serology, blood typing, and Rh factor shall be included as part of the examination.

(4) Evaluation.—A recruit should be considered for separation from the service when there is a demonstrated inability to perform military duty.

(5) Disposition of those recruits being considered for separation from the naval service shall be in accordance with chapter 18 and the current BUMED instruction in the 1910.2 series.

(6) Reporting.—Where the recruit is not being considered for separation, the results of the examination shall be recorded on SF 600 (Chronological Record of Medical Care) and filed in the recruit's Health Record.

15-48. Former Members Physically Disqualified for Reenlistment When Separated

(1) No former enlisted person who was discharged by medical survey or who at time of last discharge was not recommended for reenlistment due to physical disability shall be enlisted without authority from the Navy Department. In requesting authority for the enlistment, the medical officer shall submit a complete report of notations made on the last discharge and a statement of the applicant's present physical condition, together with the request for waiver.

15-49. Candidates for Commission or Warrant

(1) The physical examination of candidates for commissioned or warrant grade should be conducted, if practicable, by two medical officers and one dental officer of the Regular Navy or Naval Reserve or both. In instances where two medical officers and one dental officer are not readily available, the examination may be conducted by one medical officer and one dental

officer, or by one medical officer if a dental officer is not available. The services of medical officers of the Department of the Army or Air Force may be used only in instances where the services of an active or inactive naval medical officer are not available. The services of civilian physicians and civilian medical facilities may be used only when authorized by COMNAVMILPERSCOM or CMC, as appropriate, upon the recommendation of COMNAVMEDCOM. Except for members of the naval service on active duty, the services of civilian physicians and civilian medical facilities may be utilized only on a no-cost-to-the-Navy basis. Reports of examinations, recorded on Standard Form 88 (Report of Medical Examination) and Standard Form 93 (Report of Medical History), shall be submitted to COMNAVMEDCOM for review.

(2) Candidates for, or individuals enrolled in, certain officer-training programs who are not on active duty may be admitted to a naval medical facility for the purpose of conducting special physical examination procedures when the requirements of NAVMEDCOMINST 6320.3 series, section C, paragraphs 3 or 4 are met.

15-50. Candidates for Service Academies, ROTC Four-Year Scholarship Program, and Naval Academy Preparatory School (NAPS)

(1) Complete procedures for the administration and reporting of physical examinations on candidates for service academies and ROTC Four-Year Scholarship Programs are contained in BUMEDINST 6120.3 series.

(2) The Department of Defense Medical Examination Review Board (DODMERB) is a Department of Defense agency with the exclusive responsibility for scheduling and reviewing all physical examinations on candidates for the service academies and the ROTC Four-Year Scholarship Programs. Questions and problems regarding these physical examinations should be addressed to Department of Defense Medical Examination Review Board (DODMERB), U.S. Academy, Colorado Springs, Colorado 80840.

(3) All applicants for the Naval Academy Preparatory School (NAPS) shall be examined in accordance with BUMEDINST 6120.3 series. Their physical examinations reports shall be clearly marked "NAPS CANDIDATE." Instructions regarding application to NAPS are contained in OPNAVINST 1531.4 series.

15-51. Retired Members Ordered to Active Duty

(1) A member on the retired list who is

ordered to active duty, except for short periods of temporary active duty, shall be required to complete Standard Form 93 (Report of Medical History) and shall be examined physically by a medical officer who shall submit a report on Standard Form 88 in duplicate listing all defects or disabilities and expressing an opinion as to the type duty the member is physically qualified to perform. The Standard Form 93 shall accompany the original of Standard Form 88. The examinee may be found physically qualified for active duty if considered physically qualified to perform the duties to which he or she may be assigned.

15-52. Physical Examination of Active Duty Officers (Quadrennial/Annual)

(1) Purpose.—The purpose of this examination is to detect disease processes in their incipency, thereby permitting earlier therapy, and to maintain current medical data regarding physical fitness of officer personnel. Military personnel are a unique population in that they have medical care readily available at all times. It is, therefore, presumed that officers suffering minor complaints will present these at sick call and the condition can be thoroughly evaluated at that time. It is not considered necessary that all officers be examined on an annual basis during the early years of their careers. In view of the increased incident of certain disease processes in older age groups, the frequency of examination should increase in relation to the age of the individual.

(2) When Conducted.—

(a) All officers assigned to duty which requires performance of frequent aerial flights shall receive an annual flight physical examination within 30 days of the anniversary of the officer's date of birth.

(b) All flag and general officers shall receive an annual physical examination within 30 days of the anniversary of the officer's date of birth.

(c) All other Navy and Marine Corps officers on active duty shall be examined within 30 days of the anniversary of the officer's date of birth at ages 24, 28, 32, 36, and annually thereafter.

(d) A complete physical examination (such as: aviation physical per article 15-78(1), or examination incident to appointment, or discharge from hospital upon report by a medical board) conducted and reported to COMNAVMEDCOM during the preceding 12 months will obviate the need for the physical examination, except flag and general officers for whom the physical examination described by this article shall

be conducted regardless of previous examinations during the year.

(e) Any officer may, upon request, be examined at any time such examination is medically indicated.

(f) Commanding officers are responsible for instituting whatever procedures may be necessary to verify officers' Health Records periodically and to ensure compliance with this article.

(3) Conducted by.—The examination may be conducted by any medical officer of the Department of Defense on active duty. Whenever possible, and particularly for those officers over age 36, the examination should be conducted by a qualified internist (and such other specialists as may be available). For aviation personnel, at least one of the examining medical officers shall be a flight surgeon or an aviation medical examiner. Under exceptional circumstances, in foreign countries, other than flight physical examinations may be conducted and reported on by a civilian physician.

(4) Scope of the Examination.—The examination shall be sufficiently thorough, including completion of the NAVMED 6120/2 (Officer Physical Examination Questionnaire), to be reasonably certain that the officer concerned is free of incipient disease or functional impairment. All positive responses on the NAVMED 6120/2 shall be explained in block 7 of the form and signed by the examining medical officer. All positive history and physical findings shall be thoroughly evaluated. Any clue which might indicate physical or functional maladjustment shall be followed with such diagnostic, consultant, or hospitalization procedures as are indicated. Officers will be questioned specifically about the presence of a family history of cardiac disease. Officers will be questioned about the use of tobacco, including smokeless tobacco. Tobacco users will be counseled concerning the health hazards of tobacco use, and if the officer is amenable, referred to locally available smoking cessation interventions as the examiner sees fit.

(a) All Officers.—

(1) Vision.—Visual acuity shall be tested as outlined in article 15-93. If impairment exists, its degree, cause, and correctability shall be stated. If possible, the prescription for lenses necessary to correct errors of refraction shall be recorded.

(2) Color Vision.—Testing of color perception is required for all ensigns and lieutenants (junior grade) with designator codes 11xx, 13xx, 60xx, and 61xx. Testing of color perception is not required routinely for all other officers.

(3) Auditory Acuity.—If any impairment of auditory acuity has previously

been determined or is now suspected, audiometric examination is required.

(4) Dental.—A type 2 dental examination shall be provided. (See art. 6-100.) Based on the clinical and radiographic findings, the examiner shall make suitable recommendations for corrective care to attain optimal oral health.

(5) Chest X-ray.—A standard film shall be included as part of the examination, if clinically indicated.

(6) Cardiovascular.—Upon the occasion of an officer's first regularly scheduled physical examination, an electrocardiographic tracing shall be obtained unless the Health Record already contains a previous tracing. This tracing shall be retained permanently in the officer's Health Record to provide a baseline against which future studies might be compared. Electrocardiographic tracings shall be performed on all officers at the time of each physical examination beginning with the physical conducted at age 28.

(7) Urinalysis.—Routine urinalysis, including determination of specific gravity, albumin and sugar, and microscopic study, shall be performed. When specific gravity is below 1.010, a repeat urinalysis is indicated. When albumin, casts, or sugar is found in the urine, such other tests as may be indicated shall be made.

(8) Rectal.—Inspection and digital examination shall be accomplished. Proctoscopy shall be used where indicated. Digital examination of the prostate shall be done on all officers 36 years of age or over and in all others where indicated. Stool examination for occult blood shall be made for all officers over age 36.

(9) Pelvic, Vaginal, and Breasts.—A pelvic and breast examination shall be performed on all female officers. The presence of a third person is required and the examinee shall be properly draped. The examination shall include bimanual palpation, visual inspection of the cervix and vaginal canal by speculum, and a Papanicolaou smear. Where hymenal opening is smaller than usual, due care is to be given to avoid any damage to the existing hymenal ring. All female officers below the age of 36 are encouraged to request an annual Papanicolaou smear and such other examination as may be recommended by specialists in obstetrics and gynecology. Breast self-examination techniques shall be taught to female officers in conjunction with the breast examination.

(10) Testes.—An examination of the testes shall be performed on all male officers. Self-examination techniques shall be taught in conjunction with the testicular examination.

(11) Intraocular Tension.—Shall be determined on all officers who are 36 years

of age or older, and in all others in whom palpation or history is suggestive of abnormal pressure. (See art. 15-103.)

(12) Hematology, Serology, and

Chemistry.

(a) Hematocrit level shall be determined during the examination and recorded in item 50 on the SF 88. Hemoglobin determination may be substituted where hematocrit cannot be performed.

(b) Serological test for syphilis, using standard serologic techniques, shall be required at the following ages: 24, 28, 32, 36, 40, and 45 years, as attained during the calendar year of the examinations. In addition, a serologic test for syphilis shall be accomplished in any officer with a history of urethritis, venereal disease, or nonspecific penile lesion within the previous reporting period, or with unexplained lymphadenopathy or other suggestive findings.

(c) Serum total and HDL cholesterol and fasting blood glucose determinations shall be performed at the time of the initial physical exam and at all physical exams beginning at age 28.

(13) Particular attention, via individual counseling, referral to other Medical Department specialists, or referral to group lifestyle intervention classes, shall be devoted to those personnel demonstrating on an increased cardiovascular risk, based on consideration of their family history, body composition, smoking history, blood pressure, fasting blood glucose, total/HDL cholesterol, and electrocardiographic findings.

(14) The officer's Health Record shall be reviewed for completeness and verified incident to this examination. In addition, inoculations shall be brought up-to-date in accordance with current directives.

(b) Flag and General Officers. For flag and general officers, the following special procedures shall be carried out in addition to clinical and laboratory procedures listed above:

(1) Thorough ENT examination, including audiogram. In those instances where the audiogram reveals an average loss of hearing in the better ear of more than 30 decibels (ISO) in the conversational range (500-2000), the officer shall undergo speech reception and discrimination testing, if available.

(2) X-rays, using 14 x 17 inch (35.46 x 43.18 cm) film, of chest at inspiration and expiration in the postero-anterior view and left lateral view, if clinically indicated.

(3) Blood sugar drawn 2 hours after breakfast or lunch.

(4) Appropriate blood chemical

tests (12 channel autoanalyzer series, if available).

(5) White blood cell count (differential to be done if white blood cell count is abnormal).

(6) A sigmoidoscopic examination and barium enema should be performed if the stool examination for occult blood is positive or if a need indicated by history of symptomatology.

(5) Review and Evaluation.

(a) Review. The examining medical officer shall be responsible for the review of all physical examinations personally conducted. Upon signing the SF 88, the medical officer certifies that, to the best of the certifier's professional knowledge, the information is complete, accurate, and authentic. Reviewing medical officers at higher levels of command are charged with the responsibility of ensuring that the SF 88 is complete and properly executed, and that there is adequate documentation to support the examining officer's findings and recommendations.

(b) Evaluation. In the clinical evaluation of any positive findings, particular care must be taken to record a clear, exact, and complete report of the condition. This evaluation should include all significant objective findings which substantiate clinical diagnosis. Adequate information must be given to enable reviewing officials to make appropriate determinations. In this connection, free use of consultations should be made. When made, a report of the consultation shall be attached to the SF 88 and a brief description of the defect which necessitated the consultation shall be recorded in item 73 on the SF 88. An officer who presents either a manifest or latent impairment which is likely to render the officer unfit in the near future will be considered to be unfit for duty, even though the officer may be physically capable of performing all duties at the moment. Conversely, an officer convalescing from an illness or injury and who is likely to recover to a degree which would permit performance of all duties in the near future will be considered to be fit for duty. In general, an officer should be considered unfit when it is determined that the officer is unable because of disease or injury to perform all the duties of office or grade in such a manner as to reasonably fulfill the purpose of employment on active duty. In the event a defect or condition is discovered which is later proven to be benign or of no significant consequence and which may be a recurrent finding on subsequent physical examinations, a copy of the consultation or narrative summary shall be permanently retained in the officer's Health Record. Additionally, the officer concerned may be provided a copy of the

applicable consultation or narrative summary for personal files. The medical examiner shall inform the officer concerned when an entry is made on the examination report which may adversely affect, in other than a temporary degree, efficiency in the performance of duty. (See U.S. Navy Regulations.)

(6) Disposition.--Disposition depends upon many factors, any number of which may apply in a particular situation. The object is to institute indicated measures early enough to protect the officer's health, to protect the command against continuing to depend upon an officer who is unable to properly perform duty, and yet to interfere in the least possible manner with the activities of the officer concerned. When no conditions of import are noted, no action is required. The discovery of conditions of import may only require imparting of appropriate clinical advice; or it may require consultations, or continuing observation, or ambulatory treatment in a duty status; or hospitalization either immediately or at some opportune time in the future. Indiscriminate or repeated transfers to a hospital are to be avoided with preference given to consultant studies from a duty status. Officers hospitalized for study or treatment as a result of a physical examination shall be further reported upon by a medical board prior to discharge from the hospital.

(7) Reporting.--In all instances where an examination is required, an SF 88 shall be prepared in such completeness as necessary and shall contain entries regarding opinions and recommendations of the examiner. The SF 88 may be either handwritten in black or blue-black ink or typed. Should the examination not be required, the reason shall be entered on an SF 600 and filed in the officer's Health Record (see art. 15-52(2)(d)). The original SF 88 and questionnaire shall be filed in the officer's Health Record except for the following:

(a) Flag and General Officers.--Submit to COMNAVMECOM (MEDCOM-25) a copy of the completed SF 88 and questionnaire, and a copy of all medical information entered in the officer's Health Record subsequent to completion of the previous annual physical examination, including narrative summaries, consultation reports, sick call treatment records, EKGs, x-rays, and laboratory reports. Upon completion of the first annual physical examination subsequent to promotion to flag or general rank, a copy of the officer's entire Health Record shall also be submitted. All original Health Record entries and documents are to be retained in the Health Record.

(b) Aviation Personnel.--Submit original SF 88 and questionnaire to NAMI

(NAMI-14) in accordance with applicable guidelines set forth elsewhere in this chapter. File copy of SF 88 and questionnaire in officer's Health Record.

(c) Divers.--Submit copy of SF 88 and questionnaire to COMNAVMECOM (MEDCOM-21) in accordance with article 15-36(1). File original SF 88 and questionnaire in officer's Health Record.

15-53. Annual Physical Examination of Certain Enlisted Members

(1) Purpose.--The purpose of the examination is to detect acute or chronic incipient disease processes, thereby permitting early therapy; and to determine the presence of defects which might be expected to preclude reasonable performance of sea or field duty or which might be a hazard to the member in the performance of such duty.

(2) To Whom Applicable.--Enlisted active duty members (both male and female) who have not otherwise undergone a complete physical examination within 12 months:

(a) Age 36 and over, Navy and Marine Corps, shall receive an examination within 30 days of the anniversary of their birthdays.

(b) Applicable aviation personnel shall be examined in accordance with section V of this chapter.

(c) To determine combat readiness, marines who are 36 years of age or older and serving at Marine Corps bases or camps, recruit depots, air stations, air facilities, Marine Corps schools at Quantico, and with Fleet Marine Force units shall receive a physical examination within 30 days of the anniversary of their birthdays.

(d) Females, under age 36, shall be encouraged to request an annual physical examination similar to that for female officers in article 15-52. (Instructions concerning the annual physical examination of inactive enlisted members of the Naval and Marine Corps Reserve are contained in article 15-84.)

(3) Responsibility For.--Commanding officers are responsible for instituting whatever procedures may be necessary to ensure that the members in (2) (a), (b), and (c), and when necessary (d), obtain the required examinations.

(4) Conducted By.--The examination may be conducted by any medical officer of the Department of Defense on active or inactive duty. Insofar as practicable, the examination shall be accomplished by Medical Department personnel organic to the member's unit. Attention is directed to article 15-67 for applicable aviation personnel.

(5) Scope of Examination.--The examination

will conform to all requirements described for officers in article 15-52(4). Hospitalization should only be effected if necessary for completion of indicated studies or for evaluation of the significance of abnormalities noted.

(6) Disposition.—When significant defects are detected, it must be the responsibility of the examining medical officer to inform the member's commanding officer of the existence of such defects and make specific recommendations for such corrective or remedial measures as may be deemed appropriate.

(7) Reporting Procedures.—Except for aviation personnel, the results of the examination must be recorded on the SF 600 and filed in the Health Record. The entry must include the date of examination, title of the examining activity, all defects noted, specific comment to physical fitness for performance of duties, at sea, foreign shore, or in the field, as appropriate, and the signature of the medical examiner. For members in articles 15-53(2)(a) and (c) not needing a birthdate examination by reason of another complete examination during the past 12 months, an entry to the obviating examination must be made on the SF 600 during the birthdate period. A copy of the report of annual physical examination is not required nor desired in COMNAVMEDCOM, except those of aviation personnel. The recording and forwarding of physical examinations of applicable aviation personnel must be as stated in article 15-77(5).

15-54. Physical Examination of Naval Academy Midshipmen, NROTC Applicants, and Students

(1) A periodic and precommissioning physical examination of Naval Academy midshipmen must be conducted following regulations governing the Naval Academy and at such time as may be determined by the Superintendent.

(2) Applicants for the NROTC program must meet the physical standards of articles 15-8 through 15-28. For further guidance regarding the physical examination of NROTC Scholarship applicants refer to NAVMEDCOMINST 6120.2 series. The completed SF 88 and SF 93 on NROTC College Program applicants must be sent following article 15-90.

(3) An annual physical examination of NROTC students is not required; however, the commanding officer of each unit is responsible for ensuring that each student

completes a NAVMED 6120/3 form annually during the fall semester, and again during the spring semester immediately before graduation. In the event a student answers "YES" to question one, the commanding officer must send copies of abstracts of treatment, narrative summaries, or other available medical records pertaining to the injury, illness, or disease resulting in hospitalization or absence from school, to COMNAVMEDCOM (MEDCOM-25) for review. Students answering "YES" to question two must be referred to the nearest Federal medical facility for evaluation of the alleged defect. Send a copy of the evaluation report to COMNAVMEDCOM (MEDCOM-25) for review. Evaluation reports from civilian consultants are acceptable if a Federal medical facility is not available. Notwithstanding the foregoing, the commanding officer is responsible for sending a report to COMNAVMEDCOM (MEDCOM-25) on any student who at any time becomes disabled for a significant period of time or contracts a disease or injury that may render the student "Not Physically Qualified" for commissioning. The completed NAVMED 6120/3 form is to be filed in the student's Health Record. NAVMED 6120/3 forms may be ordered through the supply system as directed in NAVSUP Publication 2002 for Cog 11 items.

(4) NROTC students must receive a complete physical examination within 1 year before the anticipated date of commissioning. The completed SF 88 and SF 93 are to be sent following article 15-90, not later than 1 October of the year before the anticipated date of graduation. Embarkation points receiving NROTC students for their first class cruise must arrange for precommissioning physical examinations to be conducted locally, provided that time and facilities permit. If such physical examinations are not conducted before embarkation, the commanding officer of the ship or station to which the student is transferred for the first class cruise must arrange for the precommissioning physical examinations to be conducted during the cruise. However, units located in close proximity to Navy medical facilities should use those facilities to the maximum extent possible, consistent with class schedules, submission date deadline, and the 18-month validity period for precommissioning physical examinations. Orders must be endorsed by the unit commanding officer to indicate whether or not a precommissioning physical examination is required at the embarkation point of NROTC students.

15-55. Promotion of Navy and Marine Corps Officers on Active Duty

(1) See MILPERSMAN 2220150 and MCO P1400.29, paragraph 2405.1b, for current policy on promotion physical examinations for officers on active duty.

15-56. Separation From Active Duty

(1) Before separation from active duty (e.g., voluntary or statutory retirement, discharge, expiration of enlistment, transfer to Fleet Reserve, etc.), every member must be given a thorough physical examination. However, a member who has been evaluated by a medical board incident to separation from active duty need not undergo further physical examination at the time for separation. For members separated by reason of aptitude board action, see (7) below. All necessary tests and examinations must be completed, interpreted, and properly recorded to ensure that the member is, in fact, physically qualified for release from active service before actual date of release. Pelvic examination of female members must be included as part of the examination. See NAVMEDCOMINST 6224.1 series concerning the tuberculin skin testing and chest x-ray requirements for a member being separated from active duty. In addition, an approved serologic test for syphilis must be performed on each member within 6 weeks before separation. Those personnel participating in the separation leave program promulgated by MILPERSMAN 3810260 are authorized to complete serological and tuberculosis skin testing 10 weeks before expiration of active obligated service (EAOS). See also article 16-13 concerning the examination of a member convicted and held by civil authorities.

(2) Whenever a physical condition is discovered which might have serious impact, or if a member alleges to be unfit to perform the duties by reason of physical disability and there is reasonable evidence to support such claim, the member must be afforded inpatient or outpatient study sufficient to thoroughly evaluate the member's physical fitness. If a condition is found which is sufficient to physically disqualify the member for continued active service, the member must be reported upon by a medical board (see chap. 18).

(3) Each member must be required to read the following statement at the time of examination for separation:

"You are being examined incident to your separation from active duty. If you feel you have a serious defect or condition that interferes with the performance of your military duties, advise the examining physician. If you are considered by the

physician to be not physically qualified for separation, you will be referred for further evaluation, and if indicated, appearance before a medical board. If, however, you are found physically qualified for separation, any defects will be recorded in item 74 of the Report of Medical Examination (SF 88). Such defects, while not considered disqualifying for military service, may entitle you to certain benefits from the Veterans Administration. If you desire further information in this regard, contact the VA office nearest your home after your separation."

The member will also be requested to sign the following entry in item 73 on the SF 88: "I have been informed of and understand the provisions of article 15-56(3) of the Manual of the Medical Department." Refusal of the member to sign the foregoing entry must not delay separation. Rather, the examining physician must note in item 73 that the provisions of MANMED 15-56(3) have been fully explained to the member, who declines to sign a statement to that effect.

(4) Each member separated from active duty must be given a signed, legible completed copy of the separation SF 88 form.

(5) An enlisted member who is retained beyond expiration of enlistment for additional care, or who persists in a desire to be separated on a scheduled date of separation and before receiving medical care to which entitled, must be handled following MILPERSMAN 1050155.1e or MARCORPSEPMAN 7006, as appropriate.

(6) A member with a nontrivial disease in a communicable state (e.g., tuberculosis, venereal disease, etc.) will not be separated until rendered noninfectious and is not a danger to the public health. An exception to the foregoing would be a member being separated via medical board or PEB action. See article 15-56(5) concerning retention of a member for medical care beyond expiration of enlistment. See also article 22-21(1) concerning the reporting requirements for a member with a potentially hazardous communicable disease, who insists on being separated on the scheduled date of separation.

(7) A recruit or trainee discharged by reason of aptitude board action need not undergo a separation physical examination if 90 days of active duty have not been completed. Rather, the following entry must be made on Standard Form 600, signed by the member, and witnessed by a Medical Department representative:

"You have been examined during the past 90 days and are considered physically qualified for separation from active duty. No defects have been noted which would disqualify you from the performance of your duties or entitle you to disability benefits

from the naval service. Should you believe that the foregoing is not correct, a medical officer will evaluate your claim and, if indicated, refer you to an appropriate facility for further study. To receive disability benefits from the Navy you must be found unfit to perform the duties of your office, grade, or rating because of disease or injury incurred while you are entitled to receive basic pay. After you are separated, any claims for disability benefits must be submitted to the Veterans Administration. You will indicate by your signature that you understand the foregoing statements."

A recruit or trainee discharged by reason of aptitude board action who has served 90 days or more on active duty shall be examined prior to discharge in accordance with (1) above.

15-57. Transfer of Personnel (Officer and Enlisted)

(1) Transfer Within the U.S. (Except to isolated duty stations) or From Overseas or Sea Duty to the U.S.-Prior to transfer, the member's health and dental records shall be assembled and screened by appropriate medical personnel to determine medical acceptability for transfer. Unless the member is personally picking up the health and dental records, the member does not have to be present when the records are screened. An entry that the records have been screened shall be made on the SF 600, dated, and signed. The assembled records shall be provided to either the member or the cognizant personnel office responsible for transfer of the member.

(2) Transfer to Sea or Overseas Duty, or to Isolated Duty Stations Within the U.S.-Reference can be made to the following directives which designate sea, overseas, or isolated duty stations: Navy-OPNAVINST 3111.14 series; Marine Corps-MCO 1300.8, 1300.9, and 1306.2 series; and BUMEDINST 1300.1 series for suitability processing for overseas assignment of Navy and Marine Corps members. Prior to transfer, the member shall be referred to the cognizant medical facility where health and dental records shall be assembled and reviewed by appropriate medical personnel. At this time the member shall be questioned concerning the member's physical condition, with special emphasis being given to recent serious illness, injury, or operation. In evaluating an individual's physical fitness for such assignment, the effect of any physical conditions found should be considered in relation to the member's age, experience, motivation and ability to complete such tour of duty. Members ordered to remote or isolated duty stations should

have no physical or dental defects which are likely to require extensive or prolonged treatment. Where necessary, priority for needed medical or dental treatment shall be given to individuals scheduled for such assignments to meet the anticipated transfer date. An entry that the records have been screened shall be made on the SF 600, dated, and signed. The assembled records shall be provided to either the member of the cognizant personnel office responsible for transfer of the member.

(3) Not Physically Qualified for Transfer.-A member considered not physically qualified for transfer shall be referred to an appropriate medical facility for evaluation, and the member's command shall be notified immediately so that indicated administrative action can be initiated. Defects or disabilities which were waived at the time of original entry into the service or upon reporting for active duty shall not be considered disqualifying unless substantial changes have occurred.

(4) Immunizations.-The immunization requirements in BUMEDINST 6230.1 series shall be met incident to all transfers.

(5) Notification of Noncompliance.-When personnel are received at ports of embarkation, on board ship, or at overseas stations without required physical examinations, immunizations, or dental treatment, or with incomplete health, dental, or outpatient treatment records, the deficiencies shall be reported to the commanding officer with a recommendation that the matter be brought to the attention of the member's former military command so that the deficiencies with respect to future transfers may be corrected promptly. Copy of such communications should be provided to COMNAVMEDCOM.

15-58. Weight Control

(1) General.-Excess body fat is a serious detriment to health, longevity, stamina, and military appearance. Medical officers must be alert to identify obese members and those who show tendencies for becoming obese, and recommend preventive and remedial regimens to the commanding officer.

(2) Responsibilities.-The commanding officer is responsible for the overall administration and enforcement of the command weight control program as set forth in OPNAVINST 6110.3 series, MILPERSMAN 3420440, and MCO 6100.3 series. Medical officers are responsible for participating in the enforcement of the weight control program as directed by the commanding officer. Medical officers are specifically responsible for:

(a) Familiarizing themselves with the foregoing directives. (The administrative

processing instructions contained in those directives generally apply only to enlisted members.)

(b) Monitoring and assessing body weight as a routine part of their daily contact with members at sick call and when conducting physical examinations.

(c) Evaluating obese and overweight members to rule out underlying or associated disease processes, and assessing the effect of excessive body fat upon a member's fitness for duty.

(d) Recommending weight reduction goals and prescribing diets and exercise programs to fit the needs of each individual.

(e) Providing the commanding officer with the names of obese members and recommending appropriate courses of action in each instance based upon a professional opinion regarding the likelihood of success in a weight reduction program. This action is particularly important where obese members are being examined for reenlistment.

(f) Periodically reevaluating members participating in a weight reduction program, assessing their progress, and keeping the commanding officer informed of the progress in each instance.

(3) Application of the Weight Standards. The weight charts contained in OPNAVINST 6110.3 series and MCO 6100.3 series, as appropriate, must not be arbitrarily construed or applied. The fact that a member's weight exceeds the maximum for height and age will not be used as the sole criterion for classification as obese. An evaluation of the body build, muscular development, and bone structure should be made, noting the proportions, symmetry of the various parts of the body, chest development, abdominal girth, and the condition and tone of the muscles. An overweight member, who is obviously active, of firm musculature, evidently vigorous and healthy, and who presents a satisfactory military appearance, should not be classified as obese. In situations of noncompliance with the standards established by previously stated instructions, a waiver for general or special duty must be obtained. Front and side view photographs in bathing suit and uniform, a complete physical examination report (SF 88), and appropriate comments and recommendations from the medical officer and commanding officer shall be submitted to CMC (Code MMSR) or COMNAVMILPERSCOM (NMPC-63) via COMNAVMECOM.

15-59. Enlisted Applicants for Service Schools

(1) Enlisted applicants for assignment to service schools shall be processed in accordance with article 15-57(1) and shall

meet such other physical requirements as maybe set forth elsewhere in this Manual or other current instructions.

(2) Members requiring medical attention or who may require extensive dental treatment during the period of instruction shall be given such care as may be required on a priority basis to meet anticipated transfer dates.

15-60. Applicants for Mess Management Specialist Ratings

(1) When practicable, applicants for mess management specialists ratings shall be examined for the presence of intestinal parasites, which, if found, shall constitute cause for rejection. They shall also be examined for venereal disease and shall not be accepted while such disease exists. To be accepted for this rating, applicants must not be subject to recurring skin disease, must be neat in appearance and clean in habits, and must be free of dental diseases, especially such conditions as heavy calculus deposits, Vincent's infection, gingivitis, and periodontoclasia. Preference should be given to those candidates not requiring prosthodontic treatment.

15-61. Prisoners

(1) All prisoners arriving at a naval place of confinement shall be examined by a medical officer. (Screening prephysical examinations may be performed by paramedical personnel). See SECNAVINST 1640.9 series, Department of the Navy Corrections Manual.

(2) Neither segregation nor restricted diet should be imposed as a disciplinary measure unless the medical officer certifies in writing that it will probably not result in any serious deterioration of the prisoner's health.

15-62. Deserters

(1) The physical examination of a deserter shall conform to the type prescribed for entrance into the Navy, with special reference to the individual's mental condition including, if possible, an examination by a psychiatrist. The medical officer making the examination shall furnish the commanding officer a report thereof, including a statement of the nature and cause of any defects or disabilities found.

15-63. Civil Employees

(1) The commanding officer of each naval activity, having a board of Office of

Personnel Management Examiners, shall recommend to the Office of Personnel Management, through the regional director, a Medical Corps officer of the Navy to be designated a member of that board for the purpose of conducting physical examinations and executing medical certificates free of charge for applicants for, and in some instances, occupants of, groups I, II, III, and IV(a) and IV(b) positions. The duties imposed on Medical Corps officers are primarily for the protection of the Government, and therefore, no fee shall be exacted for such examinations. In view of the liability under the Employees' Compensation Act and the Civil Service Retirement Act, careful execution of this work is important.

(2) Physical examination of civilian employees shall be made in accordance with existing rules and regulations of the Office of Personnel Management and with instructions issued by or under the direction of the Secretary of the Navy.

(3) Reports of physical examinations shall be submitted on such forms as are required by the Office of Personnel Management, and by or under direction of the Secretary of the Navy.

(4) Medical Corps officers shall make physical examinations of civilian employees or annuitants in connection with disability retirement under the Civil Service Retirement Act when requested to do so by the commanding officer or by the Office of Personnel Management. In no event shall a Medical Corps officer be required to leave an assigned station for the purpose of making such an examination, since only in instances where the applicant is able to appear will a Medical Corps officer be requested to make an examination. (For duties of Medical and Dental Corps officers in connection with the Federal Employee's Compensation Act, reference should be made to sec. G, NAVMEDCOM 6320.3 series.)

(5) (a) The routine roentgenographic examination of the chest of civilian employees of the naval establishment is authorized by law as part of the program for promoting and maintaining the health of Federal employees.

(b) Whenever practicable, a roentgenographic examination of the chest shall be made as part of the physical examination for employment within the naval shore establishment. If it is impracticable to obtain the examination or to have the examination interpreted, arrangement for such examination shall be made at the first opportunity. Personnel who have roentgenographic findings of possible future clinical significance shall receive the examination every 6 months, where possible, using 14 x 17 inch (35.46 x 42.18 cm) film. Roentgenographic examination of the chest of

all persons employed within the naval shore establishment shall be made, when practicable, immediately prior to leaving employment, except when such examination has been made, and recorded as without defect, within the previous 6 months.

(c) For processing reports and records, see article 15-101.

(6) Tuberculin skin testing of all persons employed within the naval shore establishment having "negative" skin tests (defined in 15-102(3)(c)) shall be conducted, if practicable, once a year on a voluntary basis. These tests are mandatory for all persons with "negative skin tests" employed within the naval shore establishment located in the Far East and other areas where the rate of tuberculosis is considered high. Personnel in these areas who have positive tuberculin skin tests must receive an annual chest x-ray in lieu of the tuberculin test.

15-64. Evidence of Intoxication or Drug Addition

(1) Reference should be made to BUMEDINST 6120.20 series for guidance in conducting and recording fitness-for-duty examinations.

15-65. Members on Temporary Disability Retired List

(1) Statutory regulations require that members carried on the temporary disability retired list (TDRL) be examined at least once every 18 months. The examination shall be conducted in accordance with the guidelines in the Disability Evaluation Manual. The primary purpose of the examination is to evaluate any changes that may have occurred in the member's condition since last examined. The report of examination should include a description of any other defects that were incurred or discovered after the original retirement. Diagnostic laboratory and radiological procedures are to be employed only to the extent necessary to establish accurately the member's current status. The report shall include a statement by the examiner as to prognosis.

(2) COMNAVMILPERSCOM or CMC, as appropriate, issues orders for the periodic examinations. The original of these orders will be married with the applicable medical records at the departmental level and forwarded to the designated Armed Forces medical facility for scheduling and processing. Whenever possible, the examination shall be scheduled during the month specified on the orders.

(3) Upon completion of a periodic examination, the report of the examination shall be prepared in letter form and

forwarded together with the medical records, within 15 working days, via the commanding officer of the examining facility, to the Central Physical Evaluation Board, Naval Council of Personnel Boards, Ballston Centre Tower #2, 801 North Randolph St., Arlington, Va 22203.

15-66. Physical Examination of Firefighting Instructor Personnel

(1) Purpose.-To assure that members assigned duty as firefighting instructors and exposed to smoke and its associated constituents are in all respects physically qualified for such assignment.

(2) When Conducted.-All officer and enlisted personnel assigned duty as firefighting instructors shall receive a complete medical examination prior to assignment for, and detachment from, such duty, and at least annually thereafter within 30 days of the member's birth date while assigned such duty.

(3) Scope of the Examination.-The examination shall be sufficiently thorough to assure that the member is free of incipient disease or functional impairment, and continues to meet the physical qualifications enumerated in article 15-41. In addition, the following medical surveillance tests will be performed and

entered in the Health Record: P.A. 14 x 17 inch (35.46 x 43.18 cm) chest x-ray; audiogram; vision screening; pulmonary function testing (i.e., VC, FVC, and FEV₁); EKG; CBC (i.e., differential, white blood cell, hemoglobin, and hematocrit); urinalysis (i.e., albumin, sugar, and microscopic); and liver function profile study. For personnel 35 years of age and older, these tests shall be supplemented by an exercise EKG such as the Master's two-step.

(4) Evaluation and Disposition.-The evaluation shall include all significant objective findings which substantiate clinical diagnosis. The P.A. 14 x 17 inch (35.46 x 43.18 cm) chest x-ray should be read by a diagnostic roentgenologist informed of the member's duty assignment. A member presenting a manifest or latent impairment which renders, or is likely to render, the member unfit for duty as a firefighting instructor will be considered unfit for duty as a firefighting instructor. The decision regarding fitness for assigned duties and the continuance of duty during correction of disqualifying conditions (see article 15-41) rests with the examining medical officer. Recommendations for reassignment to other duties will be made in accordance with other applicable directives and guidance.

Section V. AVIATION

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15-67. General Provisions

(1) To promote safety and to provide uniformity and completeness, an aviation physical examination will normally be performed only by an aviation designated medical officer who is on active duty, currently assigned to a flight surgeon bullet or aviation activity, and is authorized by COMNAVMILPERSCOM or by proper authority of the Army or Air Force to conduct such examinations. Only medical officers who have successfully passed a course of instruction at a school of aviation medicine of the U.S. Armed Forces leading to the designation of flight surgeon, aviation medical examiner, or aviation medical officer are so designated. The general term "flight surgeon" found throughout this chapter will refer to flight surgeon/aviation medical examiner/aviation medical officer, unless otherwise specified.

(2) The purpose of the aviation physical examination is to select for aviation duty only those individuals who are physically and mentally qualified for such duty, and to remove from such duty those who may become temporarily or permanently unfit because of physical or mental defect. The main objective in examining candidates for flight training is to select individuals who can be expected to continue to fly safely for at least 20 years. All present conditions or history of diseases which tend to be chronic, recurrent, or progressive shall be thoroughly evaluated. After designation for aviation duty, the objective changes slightly. The examiner must now determine if the individual is physically and mentally qualified to fly and in what capacity. Every attempt shall be made to protect the Navy's investment in trained personnel and to keep them flying by use of the best medical treatment known. However, at no time must safety be compromised or health endangered. Physical and mental qualifications will be based on the

flight surgeon's determination and opinion of the ability of individual aviation personnel to safely perform prescribed duties. In addition to the general service requirements, certain special requirements as embodied within this section must be met by the various groups of aviation personnel.

(3)(a) Through general usage the term "physical standards" has come to be interpreted too broadly. Specific standards are listed for enlistment, for appointment, for commission, and for entry into and retention in certain aviation programs. Once accepted, other than fulfilling specified requirements, the qualifications for continuation in any flying category will depend on the individual's ability to perform prescribed duties. Only specific listed standards can be waived.

(b) An aviation physical examination, therefore, is an examination conducted to determine whether or not a person is physically qualified and aeronautically adapted to engage in frequent aerial flights. The extent of the examination is determined by the character of the duty to be performed by the person who will make such flights.

(c) The aviation physical examination of a candidate for flight training will be more extensive than that required for a naval flight officer. Furthermore, the physical standards upon which qualification is based will obviously be more rigid for the candidate for flight training leading to the designation of naval aviator than those for a naval flight officer. Candidates applying for training which leads to appointment to a commissioned grade must meet the physical standards for general service in previous sections, unless a waiver of the physical standards is recommended by BUMED and is granted by COMNAVMILPERSCOM or CMC, as appropriate. The term "flight or aviation physical examination" is technically incomplete unless the duty which the examinee is to perform is specified.

(d) The Navy and Marine Corps need the best possible candidates. The selection of candidates involves an evaluation of the "whole person," including character, academic standing, specific skills, motivation, and other attributes in addition to physical qualification. Every effort shall be made to prevent instances wherein candidates are found to be not physically qualified on arrival at Pensacola. The submission of waiver requests for outstanding candidates is encouraged in accordance with articles 15-42 through 15-44. Such requests must be fully documented.

(e) Item 5 of the SF 88 shall contain an exact description of the nature of the examinee's duties, e.g., naval aviator, candidate naval aircrewmember, naval flight officer, SAR crewmember, etc.

(4) Equipment and personnel for conducting the physical examination for flying have been provided aboard aircraft carriers, at fleet air bases, within certain flag commands, at Navy and Marine Corps air stations, and at other aviation activities and commands to which flight surgeons are attached.

(5) Aviation personnel include all individuals who in the performance of their duties are required to make frequent aerial flights and certain nonflying personnel. Aviation personnel are divided into two classes:

(a) Class 1.-Aviation personnel engaged in the actual control of aircraft, which includes naval aviators and student naval aviators. In this class are also included student naval flight surgeons, student aerospace physiologists, and student aerospace experimental psychologists. Class 1 is further divided into service groups I, II, and III, based on certain physical requirements indicated below in this section.

(b) Class 2.-Aviation personnel not engaged in actual control of aircraft, which includes naval flight officers, technical observers, naval flight surgeons, aerospace physiologists, aerospace experimental psychologists, naval aircrewmembers, parachute jumpers, aircontrollers, and other persons ordered to duty involving flying.

(6) An individual who applies for training leading to the designation of one of the many categories of aviation personnel which have been listed above will be known as a candidate. When the term is used, it should be qualified to indicate the category for which the individual is a candidate: for example, "candidate for SFS," "candidate for SNA," or "candidate for SNFO." Because of the special requirements for the "candidate for SNA," the physical standards and comments on the reporting of physical examinations of this group are placed in a separate article. Also presented in a separate article is the special reporting for personnel who are in flight training. These persons, though they fall into the category of class 1 personnel, must meet standards more rigid than those required for designated pilots of class 1.

(7) Electrocardiograms.-

(a) All candidates, students, and designated naval aviation personnel on active duty shall have an electrocardiogram on file in their Navy Health Records. Those who do not have one shall be given one at the time of the next flight physical examination regardless of the purpose of the examination. The baseline electrocardiogram shall be marked "not to be removed from Health Record" and shall be retained in the individual's Health Record until the record is permanently closed. A representative sample (or legible copy) of the electrocardiogram shall be mounted so that all leads are visible and forwarded to the Cardiology Department, Naval Aerospace Medical Institute, Naval Air Station, Pensacola, FL 32508. Each sample or copy electrocardiogram sent to NAMI shall bear the individual's full name, grade or rate, social security number, designator, duty status, duty station, age, height, weight, blood pressure, date, and presently recommended flight status and designation.

(b) Electrocardiograms shall be obtained on all flight physical examinations conducted on designated naval aviation personnel on the occasion of their 27th, 30th, 33rd, and 35th birthdays and yearly thereafter. The tracing shall be compared to the individual's baseline tracing in the Health Record. If significant changes are considered to be present, a cardiac consultation shall be arranged and a report thereof, together with a completed typewritten original SF 88, shall be submitted to NAMI (NAMI-14). Each new electrocardiogram shall be sent to NAMI bearing the data required in (7)(a) above.

(8) Abnormal Hemoglobin.-All personnel on active duty shall be tested for hemoglobin-S and Glucose-6-phosphate deficiency in accordance with BUMEDINST 6260.26 series (as modified by COMNAVMEDCOM 301500Z Sep 85). The following standards apply to aviation duty:

(a) Individuals with sickle cell anemia, sickle cell disease or any significant anemia will be disqualified.

(b) Individuals with sickle cell trait (SCT) and G-6-PD deficiency will not be restricted from any military specialty (aviation).

(c) If as a result of SCT an individual experiences a major physiological event which places him/her at risk for additional episodes, the individual may be disqualified.

(d) An educational/counseling program at the appropriate GEOCOM facility accession site will be provided. This must include medication to be avoided for G-6-PD deficient individuals, genetic counseling, the suspected risks associated with special duty (aviation/diving), and heat related injuries.

(9) Pregnancy.-Physical and physiological changes associated with pregnancy are considered to present a potential risk to flight safety.

(a) Pregnant personnel in class 1 or class 2 will normally be grounded for the duration of pregnancy and period of convalescence.

(b) Resumption of duty involving flying following convalescence from pregnancy will be in accordance with article 15-78(1).

(c) A waiver for continuation of limited flight status while pregnant may be considered. Requests for waiver shall be submitted to CNO (Op-05F) or if appropriate, to CMC via COMNAVMEDCOM and must be accompanied by a report of a local board of flight surgeons in accordance with article 15-80(1)(d)(2).

(10) Chest Radiographs.—Routine radiographs shall be performed only on those aviation examinations which will be forwarded for COMNAVMEDCOM endorsement, e.g., 21, 24, 27, 30, 33, 36, 39, 42, and 45 years of age and annually thereafter. Personnel requiring annual endorsement for waiver, when that waiver does not involve the chest or lungs, shall also be examined every 3 years. Otherwise, radiographs should be performed only when medically indicated.

(11) Examination.—

(a) The medical examination for duty involving flying shall be limited to members of the aeronautical organization and candidates authorized by the Commander, Naval Military Personnel Command, Commandant of the Marine Corps, or commanding officers of ships, stations, and specified units of the aeronautical organization. Once an examination has begun on a person who is either a candidate for or who is already a member of the aeronautical organization, the examination must be completed. All candidates and other individuals when specified, must, as the first step of their examination, fill out a Standard Form 93, Report of Medical History, in duplicate. The completed form shall be reviewed by the examining physician and all items checked affirmatively shall be clarified or elaborated on. Direct questioning of the examinee concerning past and present physical condition for serious illness, injury, or surgery cannot be overemphasized. An examinee who has received medical care which could significantly affect physical status shall be required, when indicated and practicable, to submit a statement from the attending physician. A family history of hereditary disease shall be evaluated and investigated when indicated.

(b) After evaluation of the Standard Form 93, the flight surgeon shall proceed with the appropriate physical examination. The results of the physical examination shall be recorded in the rough on SF 88, Report of Medical Examination. That form shall be kept on file by the examining room for a period of 3 years after the information has been used in completing the appropriate reports in accordance with the existing directives.

(c) A satisfactory medical examination must be thorough in its performance and recording so as to dispel all reasonable questions about any defect, and it must contain sufficient information to substantiate the final recommendation made by the examining physician. Before signing and forwarding, the examining physician shall review the completed report of medical examination for completeness and accuracy. Failure to do so reflects seriously on the credibility of the examination and on the thoroughness of the examiner. It must also be remembered that the reviewing authority does not have the advantage of a direct examination and must rely on the examiner's verbal picture and appropriate enclosures in arriving at a decision.

(12) An individual from another military service assigned to the U.S. Navy for training or duty shall be subject to the same requirements and standards set forth in this section, only insofar as safety and personal well-being are concerned. In all other respects, the U.S. Navy accepts the physical standards of the military service by which the individual has been found qualified for general military service and for the specified duty involving flying.

(13) Waivers.—Should it be desirable for exceptional reasons to assign an officer or enlisted member to aviation duty who does not meet prescribed aviation physical standards, a request for waiver of the standards may be submitted. The request should originate with the individual's command and be directed to COMNAVMILPERSCOM, or CMC, via NAMI (NAMI-14). An SF 88 and SF 93, containing the flight surgeon's recommendation as well as sufficient medical information to support the recommendation, must be included with the request. The waiver shall not be exercised until final approval is transmitted to the command from COMNAVMILPERSCOM or CMC.

15-68. Restrictions Until Physically Qualified

(1) Frequency of Physical Examinations.—

(a) Officer Personnel.—All aviation officer personnel, whether class 1 or class 2, will undergo an aviation physical examination within 30 days of the anniversary of their birth (see art. 15-79(1)).

(b) Enlisted Personnel.—All Navy and Marine Corps aviation enlisted personnel except as listed below, will undergo an aviation physical examination within 30 days of the anniversary of their birth at age 21, 24, 27, 30, 33, and 36 and annually thereafter. Exceptions requiring examination within 30 days of each anniversary of date of birth are as follows:

(1) Aviation physiology technicians assigned to chamber duties.

(2) Naval aircrewmembers assigned sea-air rescue Navy Enlisted Classifications (SAR NEC).

(3) Personnel engaging in flights in aircraft equipped with ejection seats.

(4) Aircontrollers (must have current FAA certificate).

(5) Enlisted crewmembers responsible for or in control of actual flight instruments (e.g., flight engineers).

(6) Personnel performing as helicopter crewchief.

(7) Antisubmarine warfare (AW) specialist personnel serving as helicopter crewmembers.

(8) Any other aviation personnel as determined at local command level.

(c) Selected Passengers. All personnel flying as "selected passengers" shall be examined as frequently as would a naval aircrewman performing the same flight duties. (They shall meet the physical standards of article 15-77(10)(a) unless a higher standard is appropriate.)

(d) Qualifications. Naval aviation personnel are considered to have passed an aviation physical examination when a flight surgeon or board of medical officers, one of whom is a flight surgeon, finds that, in consideration of the qualifications prescribed in this Manual, they are physically qualified and aeronautically adapted for flight duties appropriate to their designation or candidate status. Except as authorized under subarticles (5) and (6) below, no person shall assume duty involving actual control of aircraft until notification has been received from COMNAVMECOM that the person is physically qualified for that duty.

(e) Waivers. Aviation personnel assigned to remote activities where medical officers trained in aviation medicine are not available on a regular basis may request a waiver of the requirement for an aviation physical examination within 30 days of the anniversary of their birth. Requests for waiver may be submitted in accordance with OPNAVINST 3710.7 series.

(2) Candidates for flight training who fail to attain the qualifying scores on psychological tests, as specified in technical memoranda and directions of COMNAVMECOM will not be examined.

(3)(a) All candidates for any category of aviation personnel, whether or not they are already in the naval service, must pass the appropriate flight physical examination before assignment to duty involving instructional flight. Such examination must be performed within 12 months prior to assignment, except for NROTC students who may be examined up to 18 months in advance.

(b) Candidates shall be informed that they shall be subject to further examination

as prescribed in paragraph (3)(c) below to ascertain if there has been any appreciable change in physical qualification subsequent to enlistment.

(c) All candidates for one of the many categories of aviation personnel, not limited to candidates for flight training, upon reporting to the Chief of Naval Air Training, but before being assigned to duty involving instructional flight, must be given a complete aviation physical examination. This examination shall include an electroencephalogram and an electrocardiogram. Those who present an abnormality shall be subjected to additional studies and may be brought before the Special Board of Flight Surgeons to determine their physical qualification for duty involving flying.

(4) Pilots of the Ready Reserve in a non-drill-pay status who apply for permission to pilot naval aircraft shall be subjected to the examination prescribed for class 1 herein unless they present satisfactory evidence that they have passed such an examination within 6 months prior to the date on which the flight is desired. For Selected Reserve and Ready Reserve pilots in a drill-pay status who serve under and are so authorized by the Chief of Naval Air Reserve Training or Commander, Marine Air Reserve Training, the interval shall not be greater than 12 months.

(5) Pending receipt of the approved copy of the record of physical examination, or certificate from COMNAVMIIPERSCOM or CMC that the record of physical examination has been approved, aviation personnel may be considered physically qualified provided an authorized flight surgeon certifies that the individual has no disqualifying physical or mental defects.

(6) When the flight status of any member of the aeronautical organization has been restricted by letter from COMNAVMIIPERSCOM or CMC, such restriction remains technically in effect until it is changed by subsequent letter from the same authority. However, to avoid delay in the return to flight status of persons who are clearly qualified to perform such duties, commanding officers are authorized, after consideration of the recommendation of a flight surgeon, to waive this technical restriction pending the final action of COMNAVMIIPERSCOM or CMC. When COMNAVMIIPERSCOM or CMC places or lists flight restrictions because of the results of a physical examination, such action is always based on the opinion of COMNAVMECOM. Submitting the completed typewritten original SF 88 directly to NAMI (NAMI-14) is all that is necessary to accomplish reconsideration by COMNAVMIIPERSCOM or CMC of any restriction, based on physical condition or lack of aeronautical adaptability, placed by COMNAVMIIPERSCOM or CMC on persons in the aeronautical organization (see art. 15-81(2)(b)).

15-69. Policies on Service Groups for Naval Aviators

(1) Assignment.—The following policies shall, in general, be followed in the assignment of aviators to flight duties:

(a) Service group I consists of those aviators who meet the physical standards of medical service group I, as specified in article 15-70. These aviators may be assigned to unrestricted flight duties as shown in the chart below under "SG I."

(b) Service group II consists of those aviators who meet the physical standards of medical service group II, as specified in article 15-71, and those aviators in medical service group I who temporarily meet the standards of medical service group II. These aviators are subject to the restrictions shown in the chart below under "SG II."

(c) Service group III consists of those aviators who meet the physical standards for medical service group III, as specified in article 15-72. Also included may be those aviators recovering from illness or injury who do not meet the physical standards for medical service group I or II. Aviators may be assigned temporarily to medical service group III for up to 6 months when they will be examined for reclassification. Should temporary disability warrant a longer period to recuperate fully, they can be retained in this group for additional 6-month periods before final classification is effected. These aviators are subject to the restrictions shown in the chart below under "SG III." Medical service group III aviators shall operate only dual control aircraft and shall be accompanied by a pilot or copilot of medical service group I or II, qualified in type. Waivers as indicated may be granted by COMNAVJILPERSCOM or CMC upon the recommendation of COMNAVJMEDCOM.

waiver shall be submitted in accordance with OPNAVINST 3710.7 series or MCO 3710.1 series.

(3) Aviators in this group are authorized to maintain an instrument card provided all other requirements are met.

(2) Physical Standards and Disposition.—

(a) The physical standards for aviation personnel in each of the foregoing service groups are set forth in articles 15-70, 15-71, and 15-72.

(b) Should any aviator fail to meet the prescribed service group physical standards for flying, and the physical defect which caused such failure is expected to exist longer than 30 days, such failure shall be recorded by completing an SF 88, and the report shall be forwarded to NAMI (NAMI-14) with a specific recommendation by the flight surgeon. COMNAVJMEDCOM will then submit its recommendation to COMNAVJILPERSCOM or to CMC for Marine Corps personnel. In general, one of the following dispositions will apply:

(1) Permitted to continued unrestricted flight status of service group subject to waiver of the standards by COMNAVJILPERSCOM or CMC for Marine Corps personnel.

(2) Restricted to flight duties of next service group; that is, from I to II, or II to III.

(3) Restricted to flight duties of lessened tempo commensurate with present temporary physical condition (limited to aviators recuperating from injuries or illness).

(4) Restricted to flight duties of service group III.

(5) Restricted from all duties involving flying with statement concerning whether a disqualifying defect is considered temporary or permanent.

(c) When an aviator fails to meet the standards or qualifications for flying in an appropriate service group, for flying in any capacity or where a decision cannot be made

OPERATIONS	SG I	SG II	SG III
Ship-F.W.	Unrestricted	Copilot only	Copilot only with waiver
Ship-R.W.	Unrestricted	Unrestricted	Copilot only
Shore	Unrestricted	Unrestricted	Copilot only aircraft commander with waiver

SG = Service group F.W. = Fixed wing R.W. = Rotary wing

(1) Service group III aviators shall normally operate only aircraft equipped with dual controls and be accompanied on all flights by a pilot or copilot of service group I or II qualified in mode aircraft operated.

(2) With the approval of the Deputy Chief of Naval Operations (Air), or CMC for Marine Corps personnel, aviators in service group III may act as pilot in command of multi-piloted aircraft as is commensurate with the physical qualifications of each aviator. Requests for pilot in command

by the examining flight surgeon, consideration shall be given to the appearance of the aviator before an appropriate board of flight surgeons. See article 15-80.

(d) When a recommendation is made to terminate flight status, COMNAVJILPERSCOM or CMC for Marine Corps personnel, will determine if the individual shall be retained within the aeronautical organization or assigned to duty outside the aeronautical organization.

(e) When waivers have been granted to class 1 personnel, annual reporting is

required in accordance with article 15-81(2)(1).

15-70. Examination and Standards for Class 1, Service Group I

(1) General Examination.—Except as modified by this article, the basic physical examination and basic physical standards for first acceptance in service group I shall be the same as those prescribed for commission. Continuation in service group I will be determined by the provisions set forth in this article and article 15-67(3)(a).

(2) History.—History of any of the following shall be considered as disqualifying: seizures, isolated or repetitive (grand mal, petit mal, psychomotor, or Jacksonian), narcolepsy or cataplexy, head injury complicated by unconsciousness in excess of 24 hours or post traumatic amnesia or impaired judgement exceeding 48 hours, repeated attacks of acute allergy, hay fever, allergic rhinitis, gastric or duodenal ulcer with or without hemorrhage, repeated use of hallucinatory drugs or narcotics, herniated nucleus pulposus with or without surgical treatment, ulcerative colitis or proctitis, psychosis, psychoneurosis, personality disorders (arts. 15-23(2), (3), and (4) refer), recent attacks of malaria, paroxysmal tachycardia, any organic heart disease, heart surgery, recurrent attacks of any of the rheumatic group, recent renal calculus encephalitis lethargica or any illness accompanied by diplopia and lethargy, or recurrent pneumothorax. For persons already in the Navy, a complete review of the examinee's Health Record is most important. Flight surgeons are authorized to postpone the examination of persons who fail to present their Health Record at the time of examination. In exercising this prerogative, due consideration must be made where access to the individual's Health Record is administratively impracticable. In such instances, the examinee shall be required to complete an SF 93. When the SF 93 is employed as part of a physical examination (mandatory for all candidates) some comment must be made by the flight surgeon when any significant item is checked by the examinee. (See art. 15-52 (4).)

(3) Therapeutics and General Fitness.—A notation shall be recorded on the SF 88 on individuals receiving medication or other therapeutic procedures within 24 hours of a flight physical examination. In general, individuals requiring therapeutics or who have observed lowering of general fitness (dietary, rest, emotional, etc.) which might affect their flying proficiency shall not be found qualified for duty involving flying. See article 15-78 and OPNAVINST 3710.7 series.

(4) Height and Weight.—

(a) Height.—

(1) Navy.—There is no aviation program entrance height standard for Navy personnel. However, to ensure compatibility with aircraft safety, weapons, and control systems, all Navy officers and officer candidate applicants for aeronautical designation shall meet the following anthropometric standards:

(a) Sitting Height (SH).—Minimum of 32.0 inches (81.3 cm) and maximum of 41.0 inches (104.2 cm).

(b) Buttock-Knee Length (BKL).—Minimum of 21.9 inches (55.6 cm) and maximum of 28.0 inches (71.1 cm).

(c) Buttock-Leg Length (BLL).—Minimum of 36.0 inches (91.5 cm) and maximum of 50.0 inches (127.0 cm).

(d) Functional Reach (FR).—Minimum of 28.0 inches (71.1 cm).

(2) Marine Corps.—Applicants for Marine Corps aviation programs must be at least 66 inches (167.6 cm) standing height as well as meet the anthropometric standards in (1) above.

(3) All Applicants.—Measurements shall be in accordance with BUMEDINST 3710.1 series. The measurements shall be recorded on the SF 88 as prescribed in article 16-38 (2)(u) and shown in article 16-74, illustration 1c.

(b) Weight.—Minimum and maximum weights shall be in accordance with the weight standards for aviation personnel, article 15-19(2), table 2. Even though an individual's weight is within the maximum standards, the individual shall be reported as not physically qualified when the examining physician considers that the weight in relation to the body structure and musculature constitutes obesity of such a degree as to interfere with the satisfactory performance of duty involving flying. Body fat as measured by water displacement, skinfold measurement, or anthropomorphic measurement should not exceed 20 percent for aviation duty.

(5) Chest.—Any condition that serves to impair respiratory function may be cause for rejection. The examinee, if an average-sized individual, should normally have not less than 3 inches (7.62 cm) of chest expansion. A variation of 1/2 inch (1.27 cm) is allowable if the individual is otherwise acceptable. Pulmonary function tests are recommended if the individual is borderline.

(6) Cardiovascular System.—Cardiac arrhythmia, or heart murmur, or other evidence of cardiac abnormality shall be the cause for careful study, to include appropriate consultations and electrocardiographic studies. Evidence of organic heart disease shall be cause for rejection. Also see following article 15-70(7).

(7) Blood Pressure and Pulse Rate.

(a) Blood Pressure.—Shall be determined first after the examinee has been supine at least 5 minutes and secondly after standing motionless for 3 minutes, preferably employing a mercurial sphygmomanometer. Prolonged bed rest shall not precede the determination of the blood pressure; however, due regard must be given to the age of the examinee and to physiological causes such as excitement, recent exercise, illness, or digestion. No examinee shall be rejected as the result of a single determination. When the blood pressure determination at the first examination is regarded as abnormal, the above procedure shall be repeated twice daily (in the morning and in the afternoon) for a sufficient number of days to enable the examiner to arrive at a definite conclusion. The first determination shall be recorded in item 57 (B&C) and the repeat determination in item 73 of the SF 88. Blood pressure determinations shall be made in accordance with the recommendations of the American Heart Association. The systolic reading shall be taken at the first auscultatory sound. The diastolic reading shall be taken when the auscultatory sound disappears.

(b) Interpretation of Blood Pressure Determination.—In examinees under 35 years of age, a persistent systolic blood pressure of 140 mm or more is disqualifying. In examinees age 35 or over, the persistent systolic blood pressure of 150 mm or more is disqualifying. A persistent diastolic blood pressure of 90 mm or more is disqualifying. When changing from the recumbent to the standing position and remaining in that position for 3 minutes, if the systolic or diastolic blood pressure is found to be persistently more than 10 mm below that of the recumbent position, it is disqualifying only if the examinee is symptomatic. In such an instance, a cardiovascular workup is necessitated. If a drop of more than 10 mm occurs, it must be noted in item 73 of SF 88 that the patient is asymptomatic. Systolic blood pressure persistently less than 96 mm is disqualifying unless a complete evaluation shows no cardiovascular or other abnormalities.

(c) Pulse Rate.—Shall be determined first after the examinee has been recumbent at least 5 minutes and then after standing motionless for 3 minutes (both determinations to coincide with the recording of the blood pressure). In the presence of a relevant history, arrhythmia, or pulse of less than 50 over 110, an electrocardiogram shall be obtained.

(d) Interpretation of Pulse Rate.—Resting pulse shall not persistently exceed 100. Standing pulse shall not exceed 110. Pulse rate of 50 or under in the presence of a negative cardiac history and in the absence of abnormal physical or electrocardiographic

findings shall not in itself be considered disqualifying.

(8) Teeth.—Any dental defect which would react adversely to sudden changes in the barometric pressure or produce indistinct speech by direct voice or radio transmission is disqualifying.

(9) Psychiatric Examination.—Following the completion of the general examination, the examiner shall make a careful study of the examinee's family history for evidence of insanity, familial traits of psychoneurotic manifestations, degenerations, and inherited deficiencies. A candidate's personal history shall be searched for significant factors which relate to the formative years that affect personality. The infantile period shall be searched for evidence of retardation. Consideration shall be given to examination of the family life, play life, school life, sex life, and a careful search for epileptic equivalents. Determine the family's attitude toward flying and the examinee's reaction to the stresses of life and general emotional response control. The object of the examination shall be to determine the individual's basic stability, motivation, and capacity to react favorably to the special stresses encountered in flying. Although this phase of the examination shall be performed routinely only on candidates for flight training who are otherwise physically qualified, it may, at the discretion of the flight surgeon be made a part of the examination of any aviation personnel. Any significant personality change in an experienced aviator should be reported when the examiner knows the pilot well enough to note such a change.

(10) Neurological Examination.—A careful neurological examination shall be made, attention being given to the following examinations and report of findings.

(a) Pupils.—Regular, irregular, equal, unequal, do or do not react to light and accommodation.

(b) Deep Sense (Romberg).—Negative, slightly positive, or pronouncedly positive.

(c) Deep Reflexes: Patellar, Biceps, etc.—Absent (0), requires reinforcement (+), normal (++) , hyperactive (+++), clonus (++++).

(d) Superficial Reflex: Abdominal, Cremasteric, etc.—Any abnormalities found.

(e) Sensory Disturbances.—Any abnormalities found.

(f) Motor Disturbances.—Evidence of muscle weakness, paresis, or any other abnormality.

(g) Trophic Disturbances.—Evidence of atrophy, compensatory hypertrophies, or any other abnormality.

(h) Tremors.—State whether fine or coarse, and name parts affected.

(i) Tics.--Specify parts affected. State whether they are considered to be permanent or due to fatigue or nervous tension.

(j) Cranial Nerves.--Examine carefully for evidence of impaired function or paresis. It should be remembered that some of the cranial nerves are subject to frequent involvement in a number of important diseases, such as syphilis, meningitis, encephalitis lethargica, and injuries to cranium.

(k) Psychomotor Tension.--Ability to relax voluntarily. This shall be tested by having the examinee rest the forearm upon the palm of the examiner and then testing the tendon reflexes of the forearm with a percussion hammer. The flight surgeon should also keep informed regarding any indication of fatigue to recognize the earliest manifestations of this condition.

(l) Peripheral Circulation.--Examine for flushing, mottling and cyanosis of face, trunk, and extremities. Question the presence of localized sweating (armpits and palms) and cold extremities. Any abnormalities disclosed on the neurological examination should be carefully studied and an opinion expressed as to their cause and significance and whether they are sufficient cause for rejection.

(11) Distant Visual Acuity.--

(a) Methodology.--Because of the extreme importance of accuracy, uniformity, and objectivity on performing this test, the examiner should be thoroughly familiar with article 15-93. Visual acuity may also be determined with the Armed Forces Vision Tester (AFVT). See article 15-95 for instructions.

(b) Interpretation of Findings.--Distant visual acuity shall not be less than 20/50 for either eye and the refractive error must not exceed that specified in art. 15-70(13). Distant visual acuity less than 20/20 in either eye must be corrected to 20/20 each eye with standard lenses prior to the next flight, and that correction shall be worn at all times while flying.

(c) The corrected visual acuity obtained with the glasses worn while flying will be reported in item 59 and their prescription entered in item 60 on the SF 88.

(d) Corrective lenses shall be mounted in aviation frames. When required, prescription sun glasses may be supplied. The wearing of contact lenses is prohibited at all times for class 1 personnel. For class 2 personnel, refer to article 15-77(1) (b).

(12) Near Visual Acuity.--

(a) Methodology.--A report of near visual acuity will be made on the SF 88 in item 61 in lieu of the no longer required report of accommodation, item 63.

(b) Procedure.--The AFVT is the preferred method in testing all aviation candidates as it tests monocular near vision. A near vision testing card is the preferred test for designated aviation personnel as it allows binocular testing. When a near vision test card is used, the card must be held at the prescribed distance from the viewer's eyes and illuminated by sufficient light. The results of the near vision test should be reported according to the Snellen Scale, i.e., 20/20, 20/40, 20/100.

(c) Precautions.--

(1) If glasses are worn for correction of distant visual acuity, they must be worn for testing near vision.

(2) Failure to read 20/40 binocularly or with each eye separately is indicative of presbyopia and corrective lenses must be prescribed correcting each eye to 20/20, and the correction must be available while flying.

(d) Minimum Qualifying Standards.--

(1) Student Naval Aviators.--Uncorrected near vision of 20/20 each eye.

(2) Class 1, Service Groups I, II, and III.--Uncorrected binocular near vision (both eyes) not less than 20/200, correctable to 20/20, with correction available while flying if uncorrected binocular near vision is 20/40 or less.

(3) Student Naval Flight Officers and All Class 2 Aviation Personnel.--Binocular near vision correctable to 20/20 and correction available while flying if uncorrected near visual acuity is less than 20/40.

(13) Refraction.--

(a) When Required.--Refraction of the eyes shall be required only on the original examination but must also be performed when visual acuity falls below 20/20. Subsequent refractions shall be required only in the event of further decrement in visual acuity.

(b) Procedure.--Before instilling a cycloplegic, it must be determined that the ocular tension is normal and that there is no evidence of glaucoma by ophthalmoscopic examination. Under the effects of a suitable cycloplegic, a retinoscopic examination is conducted and the results of the refraction verified by having the examinee read the Snellen Charts. The minimum correction required to enable the subject to read 20/20 is recorded for each eye. Correction beyond this level of visual acuity is neither indicated nor desired. For persons over 40 or for whom a cycloplegic is contraindicated a manifest refraction is acceptable, but must be so designated.

(c) Interpretation of Findings.--

(1) Examinee is disqualified if vision cannot be corrected to 20/20 O.U.

(2) Examinee is disqualified for service group I if the refractive error exceeds (minus)-1.25 diopters in any meridian (sphere and cylinder combined).

(d) After the use of a cycloplegic the examinee must wear dark glasses until the effects have disappeared. The instillation into each eye of a 1 percent solution of pilocarpine hydrochloride in distilled water will contract the pupil and thus relieve the photophobia.

(14) Depth Perception.—

(a) Methodology.—The AFVT is to be used to determine depth perception in accordance with the instructions in article 15-95. When this instrument is not available the test may be accomplished on the Verhoeff stereopter and shall be conducted as directed in article 15-96. When any correction is required to correct distant visual acuity, this correction must be worn while testing depth perception. In such instances, the results obtained shall be entered in the lower half of item 65 on the SF 88.

(b) Interpretation of Findings.—

(1) The AFVT is the preferred method of testing. However, qualifying results obtained by either method (AFVT or Verhoeff) are acceptable.

(2) AFVT: An error in group B, C, or D is disqualifying.

(3) Verhoeff: Failure to correctly report eight out of eight in two of three traits is disqualifying.

(c) Reporting.—

(1) Record name of test used in left-hand portion of item 65 of the SF 88.

(2) AFVT: In appropriate space of right-hand portion of item 65, record the letter designation of the highest group passed; example: Passed F.

(3) Verhoeff: In appropriate space of right-hand portion of item 65, record perfect score as 16/16.

(15) Oculomotor Balance.—

(a) Methodology.—The vertical and lateral phorias may be tested for with the phorometer (see art. 15-94) or with the AFVT (see art. 15-95). Conduct only if indicated on aeronautically designated personnel. Required on applicants for flight training.

(b) Interpretation of Findings.—

(1) Esophoria greater than 10 prism diopters is disqualifying.

(2) Exophoria greater than 10 prism diopters is disqualifying.

(3) Hyperphoria greater than 1.5 prism diopters is disqualifying.

(16) Red Lens Test.—Conduct only if indicated.

(a) Apparatus.—A spectacle trial frame, a red lens from the trial lens case, a small light such as an ophthalmoscope with head removed, and metric rule or tape shall be used.

(b) Procedure.—The examinee is seated in the darkroom facing the dark wall or tangent curtain at 75 cm. distance. The spectacle trial frame is adjusted into position and the red lens from the trial

lens case is placed in one cell of the trial frame. With the examinee's head in a fixed position, the small lamp is held directly before the center of the dark wall or tangent curtain at 75 cm. distance from the eyes. The presence or absence of diplopia in this position (primary) is noted. The light is then slowly moved from the central position toward the right for a distance of 50 cm. in the horizontal plane. In the same manner, the light is moved in the remaining five cardinal directions, up and to the right, up and to the left, to the left, down to the left, and down to the right. The presence or absence of diplopia in any of these positions should be noted. Normally, diplopia should not occur in any meridian within 50 cm. of the primary position. In the presence of diplopia, notation should be made as to whether it is crossed, homonymous, or vertical and the distance in centimeters from the central position at which diplopia first occurs should be recorded. When diplopia is suspected and the examinee denies its presence, a prism of 3 or 4 D. may be placed, either base up or base down, in one cell of the trial frame. If diplopia is still denied, the statement is obviously untrue.

(c) Precautions.—The head of the examinee must remain fixed and the movement of the light followed only by the eyes. No tilting or rotation of the face shall be permitted.

(d) Interpretation of Findings.—Diplopia first occurring within 50 cm. of the primary position, in any meridian disqualifies.

(17) Inspection of the Eyes.—

(a) Procedure.—Whenever possible, the eyes are inspected in bright daylight. Every pathologic condition and congenital anomaly is recorded. The following conditions may be found by this procedure:

(1) Lids.—Ptosis, blepharitis, trichiasis, entropion, ectropion, and chalazion.

(2) Tear Sacs.—Imperfect drainage.

(3) Lower Puncta.—Failure of contact with bulbar conjunctiva.

(4) Conjunctivae.—Trachoma and old scars.

(5) Corneas.—Scars, pannus, and pterygium. The wearing of contact lenses should be disclosed at this stage of the examination.

(6) Pupils.—Unequal size, irregular shape, and failure to react to light or accommodation.

(b) Interpretation of Findings.—Any pathologic condition which may become worse or interfere with the proper functioning of the eyes under fatigue or exposure to flying disqualifies.

(18) Convergence.—

(a) Near Point of Convergence (PC).—The Prince rule and a pin with a white head 2 mm.

in diameter is used. The end of the rule is placed 11.5 mm. in front of the cornea on the side of the nose. The white-headed pin is held 33 cm. away in the medial line above the edge of the rule and the examinee told to look at it intently. The pin is then moved along the edge of the rule toward the examinee. The examinee's eyes are watched carefully and the instant one swings outward the limit of convergence has been reached. The point on the rule opposite the pin is then read in millimeters.

(b) Interpretation of Findings.-A point of convergence (PC) greater than 100 mm. is disqualifying.

(c) Conduct only if indicated on aeronautically designated personnel. Required on applicants for flight training.

(19) Color Vision.-Applicants for any class 1 or class 2 designation must pass the Farnsworth Lantern Test in accordance with article 15-15 to be qualified.

(20) Field of Vision.-

(a) Procedure.-The examiner faces the examinee at a distance of 2 feet (5.08 cm). The examiner instructs the examinee to close the left eye and to fix the right eye on the examiner's left eye, the examiner's right eye being closed. The examiner then brings moving fingers in from the periphery midway between the examiner and the examinee. The examinee is instructed to say when the fingers are seen and how many. The examinee should see them as soon as the examiner, if normal. The fingers are brought in from all cardinal directions. The test is then repeated for the left eye.

(b) Interpretation of Findings.-The field of vision for each eye shall be normal as determined by the finger fixation test. Normal fields are as follows: temporary 90; supero-temporally 62; superiorly 52; superonasally 60; inferonasally 55; inferiorly 70; inferotemporally 85. When there is evidence of abnormal contraction of the field of vision in either eye, the examinee shall be subject perimetric study for form. Any contraction of the form field of 15° or more in any meridian shall disqualify.

(21) Ophthalmoscopic Examination.-Any abnormality disclosed on ophthalmoscopic examination that materially interferes with normal ocular function disqualifies. Other abnormal disclosures indicative of disease, other than those directly affecting the eyes, shall be considered with regard to the importance of those conditions.

(22) Intraocular Tension.-

(a) Requirements.-Intraocular tension shall be performed at either Quantico, VA or the Naval Aerospace Medical Institute on all student naval aviators and student naval flight officers prior to flight training. Normally, all aviation personnel will have tonometry performed coincident with

examination for COMNAVMECOM endorsement until age 36, and yearly thereafter. Schiotz, non-contact ("air puff") or applanation tonometry shall be performed by a physician, optometrist, or technician who has received instruction in the proper performance of the test. Digital palpation may be used for interval physical examination but should be considered inadequate for required examination.

(b) Procedure.-Determination of the intraocular tension should be conducted after all other eye examinations have been completed. Because of corneal denuding by tonometric measurement, a refraction (cycloplegic or manifest) should not be performed for a least 24 hours following this procedure. (See art. 15-103 for special instructions.)

(c) Recording.-

(1) Digital.-Normal, if such is appropriate.

(2) Tonometric.-As --mm Hg Schiotz with weight used, e.g., TOD 22.4 mm Hg Schiotz (5.5), in item 69 or 73 on the SF 88.

(3) Non-contact.-As N.C.

(4) Applanation.-As APP.

(d) Interpretation.-

(1) Questionable findings on palpation and ophthalmoscopic examination should be referred to an ophthalmologist for tonometric measurement and further evaluation.

(2) Tonometer readings consistently above 25 mm Hg Schiotz in either eye, or a difference of 5 mm Hg Schiotz between the two eyes, should be referred to the nearest military hospital glaucoma clinic for further evaluation.

(23) Ear.-The external auditory canals and tympanic membranes are examined by means of a speculum and good light. A perforation or evidence of current inflammation disqualifies. The presence of a small scar caused by trouble several years previously, which has not recurred and with which there is no deficiency of hearing and no evidence of other inflammation, does not disqualify. Actual perforation, or marked retraction of the drum following chronic ear disease, disqualifies.

(24) Hearing Tests.-To determine auditory acuity, the following test shall be used:

(a) Audiometric Examination.-An audiogram shall be obtained and recorded on all flight physical examinations if practicable. The frequencies of 250, 3000, 4000, 6000, and 8000 will be for record and research purposes only. They shall not be used in evaluating the flight status.

(b) Whispered Voice Test.-When an audiometer is not available, the whispered voice test will be performed. A quiet room is essential. The examinee should stand 15 feet (4.5 m) from the examiner with the ear being tested turned toward the examiner, the

other ear being covered or closed. The examiner, after full expiration, will whisper a number or word and require the examinee to repeat it. Each ear shall be tested in turn. If the examinee is unable to hear at 15 feet (4.5 m), the examiner shall approach until the examinee is able to distinguish the words or number, the distance being recorded in feet with 15 as the denominator.

(c) Interpretation of Findings.—When an audiometric examination is not available 15/15 whispered voice in each ear is qualifying. If the auditory acuity is less than 15/15 whispered voice in either ear, the spoken voice shall be recorded for record and an audiogram must be obtained. Audiometric loss in excess of the limits set forth in the following table is disqualifying:

	500	1000	2000	3000	4000	6000	8000
Frequency	510	1024	2048	2896	4096	6144	8192

ASA Standards:

Better ear	20	20	20	*	*	*	*
Worse ear	20	40	40	*	*	*	*

Maximum
loss in

decibels ISO Standards:

Better ear	35	30	30	*	*	*	*
Worse ear	35	50	50	*	*	*	*

*No requirement—record for baseline information only.

(25) Naso-Pharynx.—Any abnormality disclosed on examination indicating an estimated 50 percent or more nasal obstruction, acute or chronic sinusitis, acute or chronic tonsillitis, nasal blockage, mechanical obstruction to drainage of accessory sinuses, occlusion of one or both Eustachian tubes (see art. 15-104, Valsalva's Maneuver Modified), or other abnormalities which may seriously interfere with normal function shall be cause for rejection.

(26) Equilibrium.—

(a) Self-Balancing Test.—The candidate stands erect, without shoes, with heels and large toes touching. The examinee then flexes one knee to a right angle, being careful not to support it against the other leg, closes the eyes, and endeavors to maintain this position for 15 seconds. The findings are recorded as "Steady," "Fairly Steady," "Unsteady," or "Failed." The candidate should be instructed that this is an equilibrium test; there is no objection to assisting balance by moving and bending back and forth.

(b) Interpretation of Findings.—Inability to pass this test for equilibrium satisfactory shall be cause for rejection.

15-71 Standards for Service Group II

(1) Physical requirements for service group II shall be the same as those prescribed for service group I, with the following variations:

(a) Visual acuity shall be not less than 20/100 for each eye. When the visual acuity of either eye is less than 20/20, each eye shall be corrected to 20/20 and that correction shall be worn at all times while flying.

(b) When any correction is required for depth perception, the correction must be available at all times while flying.

(c) No refractive limits are required.

15-72 Standards for Service Group III

(1) Physical requirements for service group III shall be the same as for service group II, with the following variations:

(a) Visual acuity shall be not less than 20/200 each eye. When the visual acuity is less than 20/20 in either eye, each eye must be corrected to 20/20 and the correction must be worn while flying.

(b) There shall be no muscle imbalance (phoria of sufficient degree to result in diplopia within 50 cm. of the central position of the tangent curtain).

(c) Except for personnel aboard ship an audiogram shall be obtained. In general, defects in hearing shall not exceed the limits set forth in the following table:

Fre-	250	500	1000	2000	3000	4000	6000	8000
quency	256	510	1024	2048	2896	4096	6124	8192

ASA Standards:

Better ear*	30	30	*	*	*	*
Worse ear *	*	*	*	*	*	*

Maximum
loss in
decibels

ISO Standards:

Better ear*	45	40	40	*	*	*	*
Worse ear *	*	*	*	*	*	*	*

*No requirement—record for baseline information only.

Individuals who fail to meet these standards, but whose hearing in the opinion of the examining flight surgeon is commensurate with safety in flight shall be further evaluated by the Naval Aviator's Speech Discrimination Test. The minimum passing score on this test is 70.

(d) The diastolic blood pressure shall not regularly exceed 94 mm. The systolic blood pressure shall not regularly exceed 154 mm.

15-73. Report Examination of Class I Personnel

(1) After the examination has been completed, the examiner shall make an assessment of the individual's qualifications for flying, based upon either a review of previous entries in the Health Record or the report of the SF 93, the physical findings, and the result of the neuropsychiatric examination. While no individual will possess all good traits, or all bad ones, the examiner shall summarize impressions of the individual's aeronautical adaptability which shall be recorded as favorable or unfavorable. When an individual is found to be physically qualified but aeronautical adaptability is regarded as unfavorable, the entry of findings on the SF 88, as finally recorded, shall be "Physically qualified but not aeronautically adapted." When an individual is found not aeronautically adapted, sufficient comment and information shall be furnished under "remarks" or "notes" to justify such a conclusion. When the report of examination of class I personnel is made to COMNAVMECOM, the flight surgeon shall specify an appropriate service group. The flight surgeon may make any further recommendations or comment considered proper.

(2) Flight surgeons are directed to use freely the space on the SF 88 entitled "remarks" or "notes." In this space, the flight surgeon may feel free to express an opinion on both specific defects and the overall capabilities of the examinee. Proper use of this space often converts a report from a mere recording of a mechanical examination to a valuable vital estimation of the qualifications of the examinee. A space 4 inches (10.16 cm) on the right side of item 73 and item 74 shall be reserved for the required COMNAVMECOM endorsement (see art. 16-74 illustration 2A). Comments by the examinee or immediate superiors are occasionally most valuable especially when removal from flight status is recommended. Flight surgeons should enclose such comments in writing as addenda to the formal report whenever such information is considered relevant to making a final recommendation.

(3) Item 73 of the SF 88 must contain the appropriate endorsement in accordance with OPNAVINST 6110.1 series.

15-74. Special Reporting on Personnel in Flight Training

(1) The standards for personnel in flight training are the same as class I, service group I expect that whenever the uncorrected visual acuity of a person in flight training falls permanently below 20/20 either eye, or

whenever any other defect develops which is permanently disqualifying for appointment to ensign; a complete flight physical examination, including refraction under cycloplegic in instances of defective vision, will be done and the report shall be forwarded to NAMI (NAMI-14). It is the policy of COMNAVMECOM to advise the commanding officer concerned by message, when COMNAVMECOM considers disqualified any person who is already in flight training.

15-75. Standards for Candidates for Flight Training.

(1) Candidates for flight training shall meet all the requirements of class I service group I, with the following additions or limitations:

(a) Visual acuity must be not less than 20/20 in each eye.

(b) While under the effects of a 4 percent homatropine or 1 percent cyclogel cycloplegic, the candidate must read 20/20 with each eye with:

(1) Total myopia no greater than (minus)-0.25 diopters in any meridian.

(2) Total hyperopia no greater than (plus)+3.0 diopters in any meridian.

(3) Astigmatism no greater than (plus)+0.75 diopters. The astigmatic correction shall be reported in terms of the positive cylinder required.

(c) Hearing.—An audiogram is required on all candidates. Audiometric loss in excess of the limits set forth in the following table is disqualifying. No candidate shall be disqualified by a single audiogram. A series of three readings shall be acquired and submitted as an addendum to the SF 88 on all disqualified candidates.

Fre	250	500	1000	2000	3000	4000	6000	8000
quency	256	510	1024	2048	2896	4096	6144	8192

ASA Standards:

Better ear*	10	15	15	35	50	*	*
Worse ear *	10	15	15	35	50	*	*
Maximum loss in decibels							

ISO Standards:

Better ear*	25	25	25	45	60	*	*
Worse ear *	25	25	25	45	60	*	*
*No requirement-record information only.							

(d) Blood Pressure.—When the blood pressure estimation at the first examination is regarded as abnormal, or if there is doubt, the procedure shall be repeated twice daily (in the morning and in the afternoon)

for a sufficient number of days to enable the examiner to arrive at a definite conclusion. For civilian candidates, repeated blood pressure readings on one day will be acceptable when return on subsequent days is impractical.

(e) The Teeth.—Commissioned or warrant officers need meet only the standards in article 15-70(8). All other candidates are required to meet the standards in article 15-10.

(f) Psychological Tests.—Must pass certain psychological tests promulgated by COMNAVMEDCOM and administered in accordance with current COMNAVMEDCOM instructions.

(g) Personality Makeup.—Must demonstrate, in an interview with the flight surgeon, a personality makeup of such traits and reactions as will indicate that the candidate will successfully survive the rigors of the flight training program and give satisfactory performance under the stress of duty involving flying.

(2) Report of Medical History (SF 93).—In addition to the normal completion of the SF 93, the following contact lens statement shall be typed in item 8 and signed by the applicant: "I certify that I do not now use, nor have I ever used, contact lenses for any purpose; that I have never undergone any eye surgery; and that I am not aware that my uncorrected visual acuity has ever been less than 20/20." If the applicant cannot sign this statement, a full explanation by the examining flight surgeon including an ophthalmology consultation, shall be included.

15-76. Reporting on Candidates for Flight Training.

(1) The importance of the physical examination of a candidate should be recognized not only by the examining flight surgeon but also by the Medical Department personnel assisting in the procedure and preparing the report. Candidates often come from a great distance or from isolated ships. If the examination cannot be completed in 1 working day, the assistance of the commanding officer in making it possible for the candidate to remain available for a second working day shall be elicited. Careful planning should keep such instances to a minimum. If a report, upon reaching COMNAVMEDCOM, is found to be incomplete and must be returned, the candidate will suffer unjust delay in receiving orders and in some instances will be completely lost to the Navy or Marine Corps as a candidate. The preparation of the SF 88 of a candidate warrants the execution of extreme care by all concerned.

(2) The Dental Corps officer who performs the dental portion of the examination shall

make an entry over the signature, in the space set aside on the SF 88 for remarks of the dental officer, to the effect that the examinee "does" or "does not" meet the dental standards. The dental officer shall record disqualifying dental defects clearly and in such a manner as will preclude any doubt of the character or degree of the defect.

(3) In a report of the examination of a candidate, rigid adherence to set standards is expected. (See art. 15-12 for a frequently omitted portion of the general service requirement.) The examining officers are authorized to use freely that portion of the report which provides for the "remarks" or "notes" of the board or any one member of the board. Comments made under "remarks" are for the opinion of the examiner or examiners. No restriction is made about the source of information which might be molded into an expression of professional opinion. A final recommendation of the examiner or board of examiners must be made. When such recommendation is not consistent with standards set by COMNAVMEDCOM, the examiner shall note that fact on the form under "remarks" or "notes" and a reasonable explanation shall be made. When space set aside on the SF 88 for any special purpose is inadequate, extra sheets shall be used for recording addenda.

(4) Failure to detect disqualifying defects at the place of the first examination of a candidate for flight training results in great monetary loss to the Government because of unnecessary travel, disappointment for the candidate, and embarrassment to the original examiner.

15-77. Standards for Class 2 Personnel

(1) General Provisions.—

(a) Candidates for an aviation program that leads to appointment to commissioned grade shall meet the physical standards for commissioning.

(b) Contact Lens.—The wearing of contact lens to correct visual acuity is authorized at the option of the individual concerned. The contact lens must be procured a personal expense. The individual must be fully acclimated to the wearing of the lens, vision must be adequately corrected, and the flight surgeon must authorize the wearing of the lens by an appropriate statement on the NAVMED 6410/2, Clearance Notice (Aeromedical). At least one pair of corrective spectacles must be carried by the individual wearing contact lens. The wearing of contact lens to purposely produce a change in corneal curvature (orthokeratology) is prohibited.

(c) Item 73 of the SF 88 must contain the appropriate endorsement in accordance with OPNAVINST 6110.1 series.

(2) Technical Observer.-Candidates for orders as, and those ordered to duty involving flying as, technical observers shall meet the qualifications of the designation for which they are training. When the ultimate designation as naval aviation observer is not appropriate, and the need for officers or civilian employees to perform inflight duties is justified by reason of special qualifications, they shall meet the cardiovascular and neurocirculatory standards of service group I. They shall also meet any special requirements for particular aircraft type, e.g., ejection seat. In all other respects they shall be required to meet the standards of general service.

(3) Naval Flight Officer (NFO).-

(a) Candidates.-Physical standards are the same as prescribed for class I, service group I, with the following additions or limitations:

(1) Vision.-NFO candidates shall have distant and near visual acuity correctable to 20/20 each eye and the correction shall be worn at all times while flying. All applicants must meet the refractive standards as set forth in article 15-14(4)(b), table 3.

(2) Refraction.-Manifest refraction is required when uncorrected distant visual acuity is less than 20/40 each eye.

(3) Ocular Motility.-No obvious heterotropia or symptomatic heterophoria. (To be so stated on the SF 88.)

(4) Depth Perception.-Not required.

(5) Hearing.-An audiogram is required for all candidates. Audiometric loss in excess of the limits set forth in the following table is disqualifying:

Frequency	250	500	1000	2000	3000	4000	6000	8000
	256	510	1024	2048	2896	4096	6144	8192

ASA Standards:

Better ear* 10 15 15 35 50 * *

Worse ear * 10 15 15 35 50 * *

Maximum loss in decibels

ISO Standards:

Better ear* 25 25 25 45 60 * *

Worse ear * 25 25 25 45 60 * *

*No requirement-record for baseline information only.

(b) Designated Naval Flight Officers.-

Physical standards are the same as for class I, service group III, with the exceptions noted above in 15-77(3)(a)(2), (3), and (4). In addition, distant and near visual

acuity shall be correctable to 20/20 each eye and the correction shall be worn at all times while flying. When uncorrected distant or near visual acuity is 20/100 or less, an extra pair of corrective lenses shall be available on the person at all times while flying.

(4) Naval Flight Surgeons, Aviation Medical Examiners, Aerospace Physiologists, and Aerospace Experimental Psychologists.-

(a) Students.-Physical standards are those prescribed for Navy NFO candidates. Only those officers who meet the physical standards of class I, service group II, shall be found physically qualified to solo elementary aircraft upon completion of indoctrinal flight training. Failure to meet visual standards for solo flight shall serve to disqualify only for solo flying but shall not disqualify for other indoctrinal training involving flying as a special crewmember leading to the designation of flight surgeon, aerospace physiologist, and aerospace experimental psychologist.

(b) Designated.-When ordered to duty involving flying (not in control of aircraft), naval flight surgeons, aviation medical examiners, aerospace physiologists, and aerospace experimental psychologists shall meet the physical requirements of the appropriate service group according to their age as prescribed for class I, except for visual acuity, which requirement shall be the same as for staff officers of the general service.

(5) Naval Aircrewmembers and Noncrewmembers.-

(a) Candidate Naval Aircrewman and Initial Designation as Naval Aircrewman.-A naval aircrewman is an individual normally required aboard an aircraft for flight duties incident to the mission of the aircraft who meets current requirements. See MILPERMAN 1410240 or MCO P1000.6 series, article 2015. Unless otherwise directed by COMNAVJILPERSCOM or CMC, personnel shall not be permitted to undergo training leading to the designation of naval aircrewman unless they have been found physically qualified for such training by a flight surgeon. Such candidates shall in general meet the standards of class I, service group III, with the following exceptions:

(1) Age.-Not applicable.

(2) Height.-Minimum 60 inches (152.40 cm); maximum 78 inches (198.12 cm).

(3) Distant visual acuity shall be correctable to 20/20 in each eye, and if uncorrected distant visual acuity is 20/40 or less, correction to 20/20 shall be worn in the performance of flight duties.

(4) Ocular Motility.-No obvious heterotropia or symptomatic heterophoria. (To be stated on the SF 88.)

(5) Depth Perception and Near Vision.-Not required.

(6) Color Vision.--Required for all crewmembers except those with the following ratings: CTT, CTO, CTR, and CTI.

(7) Hearing.--Audiogram required. Flight engineers, airborne sonar operators, and flight communications operators must meet aviation candidate standards, article 15-75; others must meet service group I standards, article 15-70.

(8) Waivers.--Should it be desirable, for exceptional reasons to assign an individual to duty as a naval aircrewman who does not meet the above standards, a recommendation for waiver of the standards is to be submitted. The SF 88 must contain sufficient information to support the recommendation, and a letter from the commanding officer to COMNAVMILPERSCOM or CMC, via NAMI (NAMI-14) requesting a waiver shall be submitted with the SF 88. Final action taken on the recommendation for waiver will be transmitted to the commanding officer by COMNAVMILPERSCOM or CMC.

(b) Redesignation Aviation Physical Examination of Naval Aircrewmembers.--Physical requirements for designated naval aircrewmembers, on the occasion of redesignation examination, shall be the same as prescribed above for naval aircrewmembers and naval aircrewmembers-in-training with the following additions or limitations. Audiogram is required. Flight engineers, airborne sonar operators, and flight communications operators must meet the standards of service group I, article 15-70; others must meet the standards of service group II, article 15-72.

(c) Noncrewmember (To include Marine Aerial Observer).--An individual who is ordered to participate in regular and frequent aerial flights and who is not included in the crewmember complement as determined by CMO or CMC shall meet the physical standards in art. 15-77(10).

(d) Reports and Disposition.--

(1) The cognizant senior flight surgeon shall review the report of the required aviation physical examination to determine the individual's qualification for the recommended duty involving flying. Except when a waiver of the standards is to be recommended or when a COMNAVMEDCOM decision is desired, the reviewing examiner shall sign the appropriate endorsement in the item 73 space that is usually reserved for COMNAVMEDCOM endorsement and the SF 88 shall be filed in the member's Health Record.

(2) An SF 88 and SF 93 shall be submitted to COMNAVMEDCOM only in instances requiring a waiver or when a COMNAVMEDCOM decision is desired. (The typewritten original shall be submitted.) Compliance with article 15-67(13) is mandatory.

(3) The reviewing flight surgeon shall issue a NAVMED 6410/2, Clearance Notice, to the cognizant commanding officer at the time of successful completion of each

annual flight physical, except in those instances requiring COMNAVMEDCOM decision or a waiver of the standards.

(6) Aviation Physiology Technician (APT).--

(a) Candidates.--Physical standards are the same as prescribed for naval aircrewmembers and noncrewmembers, with the following exceptions:

(1) Age.--Not more than 31 years.

(2) Electrocardiogram.--Within normal limits.

(3) Weight.--Must meet standards for aviation personnel listed in article 15-19(2), table 2 (listed for emphasis, a recommendation for waiver will not be entertained).

(4) Baseline Sinus Radiographs.--A baseline radiograph series of the paranasal sinuses shall be performed and shall show no indications of chronic sinus disease. The interpretation shall be recorded in block 73 of the SF 88. The films shall be permanently maintained at NAMI.

(b) Designated Aviation Physiology Technician.--Physical standards are the same as prescribed for candidates except for age.

(7) Parachute Jumper (Candidate and Designated).--Physical standards are the same as for naval aircrewman with additions or limitations as follows:

(a) Visual Acuity.--Navy/Marine Corps Personnel.

(1) Navy.--Distant visual acuity shall be correctable to 20/20 in each eye. If the uncorrected distant visual acuity is 20/40 or less, correction shall be worn in the performance of parachute jumper duty.

(2) Marine Corps.--Distant visual acuity shall be corrected to at least 20/20 in one eye and 20/100 in the other eye.

(3) General.--Naval service parachute jumpers may not exceed + or -8.00 diopters of refractive error, correctable to the standards of paragraphs (1) and (2) above. Two pairs of FG-58 Aviation Spectacles, one clear and one tinted, shall be issued to each parachutist requiring correction. Comfort cable temples may be issued as a local command option.

(b) Heterophorias.--No requirement.

(c) Color Vision.--No requirement.

(d) Near Vision.--No requirement.

(e) Height.--Shall meet standards for appointment or enlistment, as appropriate, in accordance with standards of Navy or Marine Corps.

(f) Joint Movement.--No limitation of normal joint movement except that limitation which would be disqualifying for the student, may be considered as not disqualifying if, in the opinion of the flight surgeon, the experience of the jumper adequately compensates for the degree of immobility.

(g) Non-Navy Training.--Marine Corps personnel undergoing parachute jumper

training under U.S. Army cognizance shall meet the physical standards contained in AR 40-501, paragraph 7-5 (and chapter 2).

(h) Naval Test Parachutist.—Physical standards shall be the same as for parachute jumper except as follows:

(1) Depth Perception.—Normal depth perception required, corrected or uncorrected. If corrected, the corrective lenses shall be worn at all times while performing jumping duties.

(2) Spine.—Baseline radiographic study of the spine shall be performed. Candidates shall have no abnormalities considered disqualifying.

(i) EOD/UDT/SEAL.—Parachute jumpers who are members of EOD/UDT/SEAL teams are considered to be diving personnel. Their physical examination shall be conducted in accordance with article 15-36.

(j) Waivers.—If it is desirable for exceptional reasons to assign an individual to duty as a parachute jumper who does not meet these standards, a request for waiver may be submitted. The procedure in 15-77(5)(a)(8) shall apply in such instances.

(8) Aircontrollers.—Navy and Marine Corps aircontrollers shall meet the physical standards of class I, service group II, with the following additions and limitations.

(a) Articulation.—Must speak clearly and distinctly without accent or impediment of speech which would interfere with radio conversation. Voice must be well modulated and pitched in medium range. Stammering, poor diction, or other evidence of speech impediment which becomes manifest or aggravated under excitement shall be cause for rejection. A reading aloud test is required for all candidates. (See article 15-23(1)(i).)

(b) Vision.—Candidates and designated personnel shall have an unaided visual acuity not exceeding 20/200, correctable to 20/20 each eye, and must wear their correction while on duty. Aircontrollers whose vision falls below 20/200 in either eye may not engage in the control of air traffic in a control tower but may be otherwise employed in the duties of their ratings. In instances of distant visual acuity exceeding 20/100 the FAA certificate shall be endorsed with the following statement: "Limited to military aircontroller duties only."

(c) Color Vision.—Must pass the Farnsworth Lantern Test.

(d) Heterophoria.—

(1) Esophoria or exophoria greater than 6 prism diopters is disqualifying.

(2) Hyperphoria greater than 1 prism diopter is disqualifying.

(e) Depth Perception.—Not required.

(f) Tonometry.—Required annually for FAA certificate.

(g) Height.—Same standards as general service.

(h) Weight.—Candidates and designated personnel who do not meet the weight standards for aviation personnel will be placed on a weight control program. They may continue to serve in rate for a period of 6 months at which time they will have achieved, or made significant progress toward achieving, the weight standards. If significant progress is not shown, they shall be considered disqualified until meeting the standard.

(i) Age.—Not applicable.

(j) Hearing.—Audiogram required. Must meet service group I standards.

(k) Endorsements.—Physical examinations (SF 88 and 93) for aircontrollers shall be submitted to NAMI (NAMI-14) every 3 years for COMNAVMEDCOM review and endorsement as specified in article 15-81(2)(k).

(9) Helicopter Rescue Crewmen.—

(a) Candidates for helicopter crewmen shall meet the same requirements as those prescribed for naval aircrewmembers with the following additions or limitations:

(1) Age.—Applicant should be under age 30 although waiver for age may be considered on an individual basis.

(2) Height and Weight.—Applicant must conform to the aviation height and weight standards in 15-19(2) (table 2). The individual should be muscular physique without tendency toward exogenous obesity.

(3) Vision.—Applicant must have a minimum visual acuity of 20/50 each eye correctable to 20/20.

(a) Normal depth perception (aided or unaided).

(b) Near visual acuity of 20/50 in each eye.

(c) Must pass the Farnsworth Lantern Test.

(4) Ears.—Applicant must be free of any acute or chronic infection or obstruction, and the eustachian tubes must be freely patent to withstand sudden pressure changes. Audiogram should be within standards set forth in article 15-11(3).

(5) Medical History.—The applicant should be free of any chronic or recurrent disease or condition which would interfere with the successful completion of the training and rescue mission.

(6) Temperament.—Each applicant should be evaluated for emotional and intellectual fitness, reaction to stress, maturity, motivation, and aeronautical adaptability.

(b) Designated Helicopter Rescue Crewmen.—Physical standards are the same as prescribed for candidates except for age and minimum visual acuity which may not exceed 20/200 each eye, correctable to 20/20 and

that correction must be available at all times while flying.

(10) Search and Rescue Medical Technicians.—Medical personnel serving as aircrewmembers must meet the general enlisted aircrew physical standards described in article 15-77(5).

(11) Other Personnel.—

(a) When ordered to duty involving flying for which special requirements have not been prescribed, personnel shall, prior to engaging in such duties, be examined to determine their physical fitness for aerial flights. The examination shall relate primarily to the circulatory system, musculoskeletal system, equilibrium, neuropsychiatric stability, and patency of the Eustachian tubes (see art. 15-105), with such additional consideration as the individual's specific flying duties may indicate. The examiner shall attempt to determine not only the individual's fitness to fly a particular aircraft or mission, but also the fitness to undergo all required physical and physiological training associated with flight duty. No individual shall be found fit to fly unless fit to undergo the training required in OPNAVINST 3710.7 series, for the aircraft or mission. The visual acuity shall be at least 20/50 with or without correction in the best eye and if uncorrected visual acuity is 20/100 or less, an extra pair of corrective spectacles shall be available on the person at all times while flying. The examination and its evaluation shall be entered on the NAVMED 6150/2 (Special Duty Medical Abstract) of the individual's Health Record and the commanding officer officially notified. Submission to NAMI (NAMI-14) of physical examination reports on personnel in this category shall be the same as article 15-77(5)(d).

(b) Flight deck personnel serving in the functional capacity of "director", "spotter", "checker", or other such critical personnel as may be designated by competent authority shall meet the physical standards as prescribed for naval aircrewmembers and noncrewmembers with the following exceptions.

(1) Height.—Standards for enlistment.

(2) Vision.—

(a) Visual acuity not less than 20/200 O.U. correctable to 20/20 O.U., and if uncorrected visual acuity is less than 20/30 O.U., the correction to 20/20 O.U., must be worn at all times in performance of flight deck duties.

(b) Color Vision.—Normal.

(c) Steropsis as measured by.—

(1) AFVT.—Pass "B."

(2) Verhoeff.—Pass eight out of eight.

(3) Titmus Animals.—Pass three out of three.

(3) Hearing.—Baseline audiogram required and shall be followed in hearing conservation program.

(c) All other flight deck personnel shall meet the following minimal standards.

(1) Vision.—

(a) Visual acuity not less than 20/400 O.U. corrected to a BVE of 84 percent with correction to be worn at all times in performance of flight duties.

(b) Color Vision.—Normal.

(c) Steropsis.—Not required.

(2) Hearing.—Baseline audiogram required and shall be followed in the hearing conservation program.

(12) Selected Passengers.—All personnel flying as "selected passengers," as defined by OPNAV directive, shall meet the physical standards of article 15-77(10)(a) unless a higher standard is appropriate. All physical examinations for "selected passengers" shall be performed at naval aviation medicine examining facilities. Completed examinations shall be filed according to article 15-67(11)(b).

15-78. Examination for the Report of Fitness for Flying Duties.

(1) An examination or reexamination of any class 1 or class 2 aviation personnel shall be performed whenever it is necessary to determine their physical fitness to continue flying duty or flight training, or when considered necessary by COMNAVMEDCOM, CNO, COMNAVMILPERSCOM, CMC, or the commanding officer. All aviation personnel admitted to the sicklist or hospitalized shall be suspended from duty involving flying. Upon the recommendation of medical officer (not restricted to a flight surgeon), aerospace physiologist, or dental officer, the commanding officer may relieve from flying duty or suspend the flight training of an individual deemed physically unfit for such duty. In all such instances, a Grounding Notice (Aeromedical), NAVMED 6410/1 (formerly NAVMED 1380), shall be issued. When aviation personnel are subsequently found physically qualified for duty, they shall be examined by a flight surgeon and a Clearance Notice (Aeromedical), NAVMED 6410/2 (formerly NAVMED 1381), shall be submitted prior to returning to duty involving flying. On the recommendation from the flight surgeon, the commanding officer may authorize resumption of such duty or training involving flying.

(2) In those remote areas where the services of a flight surgeon are not available on a regular basis, the authority to issue an (Aeromedical) Grounding Notice may be delegated to an appropriate local Medical Department representative, i.e., advanced Hospital Corps personnel. Under these circumstances only, the authority to issue an

(Aeromedical) Clearance Notice may be delegated to nonaviation medicine trained medical officers, advanced Hospital Corps personnel (NEC 8425) who have completed a basic or refresher course in aviation medicine at a school for health sciences, Aerospace Medicine Technicians (NEC 8406), or Aerospace Physiology Technicians (NEC 8409) providing verbal or message concurrence is obtained from a flight surgeon in accordance with current directives. In those instances where aviation personnel have been hospitalized or grounded for a period of over 10 days, they must be examined by a flight surgeon prior to returning to duty involving flying. Under no circumstances will aviation personnel be issued a Clearance Notice while on any medication without concurrence from a flight surgeon.

(3) Class 1 or class 2 aviation personnel, upon reporting to a new duty station or upon reporting for duty from a protracted leave of absence or when otherwise indicated, shall be interviewed by a flight surgeon to determine their current health, verify that a current flight physical examination has been conducted, and to administratively review their Health Record. A physical examination may be conducted, if required, to determine their physical fitness to continue to resume their flying duties. The appropriate (Aeromedical) Grounding or Clearance Notice shall be completed in all such instances and the necessary notation shall be made in the individual's Special Duty Medical Abstract, NAVMED 6150/2 in the Health Record.

(4) Flight surgeons shall use Clearance Notice (Aeromedical), NAVMED 6410/2, on all individuals continued in, or returned to, flight status to ensure conformity of action on all personnel involved in flight duty. In each instance, appropriate notes and entries will be made in the Health Record and the NAVMED 6150/2, Special Duty Medical Abstract.

(5) All aeromedical Clearance Notices, NAVMED 6410/2, shall include an expiration date. In most situations, this date shall be the earliest of (a) the latest possible date of the next required physical examination as required by article 15-68(1), or (b) the date at which it is desired to have the individual return for repeat evaluation for any other reason.

15-79. Triennial/Annual and Promotion Physical Examinations

(1) Triennial/Annual.-

(a) Since all persons who actually control naval aircraft and those who perform frequent aerial flights must pass a periodic aviation physical examination in accordance

with article 15-68(1), the triennial/annual physical examination. Such physical examination is to be conducted within 30 days of the individual's birthday anniversary. Although an aviation physical examination conducted during the preceding 12 months would fulfill the requirements of an annual or triennial physical examination, it does not change the requirements of article 15-68(1) that all aviation personnel must pass a aviation physical examination within a specified period of time prior to the time duty involving flying is performed. Therefore, unless an aviation physical examination, for whatever reason, coincides within 30 days of the individual's birthday anniversary, it will not be considered as fulfilling the requirements of article 15-68(1). When a COMNAVMEDCOM endorsement is required (i.e., every 3 years), article 15-81(2) applies. In the intervening 2 years, any required aviation physical examinations shall include appropriate physical, laboratory, X-ray, or special examinations pertaining to qualifications for the appropriate aviation duty assignment (e.g., service group, naval flight officer, aircontroller, etc.) and shall be legibly recorded on the SF 88. The SF 88 shall be reviewed by a flight surgeon for completeness and accuracy prior to signing and shall be signed by the reviewing authority in item 82 prior to filing in the member's Health Record.

(b) On the annual physical examination of aviation personnel who are flag or general officers, the completed typewritten original SF 88 shall be forwarded to NAMI (NAMI-14) for endorsement and return to the Health Record. On the annual physical examination of aviation personnel with the grade of O-6, the completed typewritten original SF 88 shall be forwarded to NAMI (NAMI-14) for endorsement and return.

(c) On the annual physical examination of a service group III aviator who has been granted a pilot in command waiver by CNO or CMC the completed typewritten original SF 88 shall be forwarded to NAMI (NAMI-14) for endorsement and return.

(d) The annual physical examination on any class 1 personnel granted a waiver will be handled in accordance with article 15-81 (2)(a).

(2) Promotion.-Physical examination for promotion of officers on active duty shall be in accordance with current requirements. See MILPERSMAN 2220150 and MCO P1400.29 series, paragraph 2405.1b. Whenever a physical examination specifically for promotion is performed on a person who actually controls naval aircraft or who performs duty involving flying, the examination shall be a complete aviation physical examination.

15-80. Boards of Flight Surgeons

(1) Local Board of Flight Surgeons.-

(a) Purpose of the Board.-To provide an expeditious and impartial recommendation as to the aeronautical adaptability and physical qualifications of any member of the naval aviation community to continue in flight status.

(b) Convening Authority.-A local board of flight surgeons shall be convened by the local aviation commander on the recommendation of the individual's flight surgeon. The board may also be convened by a higher aviation commander, COMNAVMEDCOM, COMNAVMILPERSCOM, or CMC.

(c) Membership of the Board.-

(1) Medical commanders shall make every effort to provide the highest level of aviation designated medical personnel from local or nearby facilities for membership on the board. When it is not possible to meet the maximum requirements for the board, a statement of that fact shall be a part of the medical commander's nominating letter and shall accompany the final report of the board.

(2) A local board of flight surgeons shall consist of at least three flight surgeons. If three flight surgeons cannot reasonably be provided, aviation medical examiners, aviation medical officers, or other medical examiner may fill two of the seats. When an appropriate medical specialist is available, it is desirable but not mandatory, that the specialist also serve on the board. In situations involving a waiver request for pregnancy, a specialist in obstetrics will normally be assigned as a member of the board. The senior flight surgeon member shall function as the senior member of the board.

(3) Under very adverse conditions, one flight surgeon or aviation medical examiner may be considered the minimum sufficient to constitute a local board of flight surgeons.

(4) The board shall make an appropriate recommendation concerning the individual's ability to perform the special duties associated with flight status. If found unsuitable, the reasons shall be clearly defined. The decision rendered by the board shall be considered binding until reviewed by COMNAVMEDCOM.

(d) Reporting.-

(1) A typewritten report of the proceedings of the board on standard Navy stationery shall be affixed as an addendum to a complete typewritten original SF 88 with details of all pertinent findings including any relevant consultations. The full report with the SF 88 shall be forwarded to NAMI (NAMI-14) via the convening authority.

(2) The reporting for proceedings of a board involved in a waiver request for

pregnancy will follow the same format and be submitted in accordance with article 15-67(9) (c). The report must certify that the member has been thoroughly briefed on possible consequences of flying while pregnant and demonstrated appropriate knowledge and concern regarding safety hazards.

(2) Special Board of Flight Surgeons.-

(a) Purpose.-To provide special consultative services to assist COMNAVMEDCOM in evaluating aviation personnel to make a recommendation to COMNAVMILPERSCOM or CMC. The special board of flight surgeons shall examine naval aviation personnel, including flight trainees, referred to it for specialized studies for recommendation whether or not an individual is physically qualified and aeronautically adapted for duty involving flying. The board is located at the Naval Aerospace Medical Institute (NAMI), Pensacola, FL, which has the specific staff and equipment to render these unique evaluation services.

(b) Convening Authority and Composition.-The board shall be convened by the Commanding Officer, NAMI. A minimum of four flight surgeons and a dental officer shall act in each instance. All designated naval flight surgeons currently assigned to commands in the Pensacola area, on active flight orders, are automatically considered members of the board. In addition, other commands in the Pensacola area will provide to the convening authority on request, other officers of the Medical Corps, Dental Corps, or Medical Service Corps to serve as special consultants.

(c) Referral Methods and Procedures.-

(1) Flight Personnel (Less Flight Trainees and Pensacola Area Personnel).-COMNAVMEDCOM may, in special instances, request examination of flight personnel by the board. A commanding officer, preferably on the advice of a local board of flight surgeons, may request examination of flight personnel by the board in accordance with the following procedures:

(a) The referring command shall prepare a complete typewritten original SF 88 and SF 93 with appropriate clinical addenda describing the basic defect and furnishing all pertinent history, physical findings, and reports of all special examination. Comments by the examiner and commanding officer are desired when appropriate.

(b) This complete report outlining the need for a more extensive examination, shall be forwarded to NAMI (NAMI-14) via the commanding officer's immediate superior. If, because of deployment or for some other reason, the physical location of the immediate superior would cause undue delay in forwarding the recommendation, it may be forwarded via the nearest available flag or general officer or more senior Navy or Marine Corps aviation command.

(c) If approved by COMNAVMEDCOM, a recommendation will be made to COMNAVMILPERSCOM or CMC that the examinee be ordered to report to NAMI for referral to the board. As a general policy, personnel on the sick-list, on limited duty, or those ordered to appear before a physical evaluation board will not be referred to the board.

(d) Upon issuance of orders by COMNAVMILPERSCOM or CMC, COMNAVMEDCOM will forward appropriate records to NAMI.

(e) The Health Record, Flight Log Book, NATOPS Flight Training Jacket, and Aviation Qualification Jacket shall accompany each examinee.

(f) Personnel ordered to appear before the board shall be directed to report prior to 0800 on the Monday preceding the first or third Friday of the month.

(g) In exceptional situations in which a more expeditious evaluation is required for operational or administrative reasons, the commanding officer of the aviation person involved is authorized to communicate directly with the Commanding Officer, NAMI requesting authorization to order the individual to the board. Upon approval of the Commanding Officer, NAMI, the individual may be ordered directly to the board without reference to COMNAVMEDCOM, COMNAVMILPERSCOM, or CMC using funds from the parent command.

(2) Flight Trainees.—A flight trainee reported as not physically qualified or not aeronautically adapted for duty involving the actual control of aircraft may, if appropriate, be ordered by the functional commander, on the recommendation of the trainee's commanding officer, to report to the Commanding Officer, NAMI for referral to the board.

(3) Other aviation personnel attached to Pensacola area commands where travel funds are not involved may, if appropriate, on the recommendation of the individual's commanding officer (preferably on the advice of the local board of flight surgeons) be ordered by the functional commander to report to the Commanding Officer, NAMI for referral to the board. When an individual is ordered to the board, the individual's commanding officer shall provide to the Commanding Officer, NAMI the information required by subarticles (2)(c)(1) (a) and (e). The reporting procedures shall be as noted in the following subarticle (e).

(d) Travel.—

(1) COMNAVMILPERSCOM or CMC will issue temporary additional duty orders for personnel covered by subarticle (2)(c)(1). Funding will be provided by the parent command unless otherwise indicated.

(2) Flight trainees required to use travel funds shall be issued temporary additional duty orders by their functional commanders.

(3) Travel orders are not required for trainees in the Pensacola area.

(e) Reports.—Flight Personnel, Including Flight Trainees.—The Commanding Officer, NAMI shall submit the findings of the board to COMNAVMILPERSCOM. The report shall consist of the complete original typewritten SF 88 with details of all pertinent findings and recommendations on the individual's physical fitness and aeronautical adaptability for duty involving flying or the actual control of the aircraft.

(3) Board of Flight Surgeons at the Naval Medical Command, Washington, DC.—In those instances where appeal of a recommendation or decision is requested, COMNAVMILPERSCOM or CMC will convene a formal board of senior flight surgeons at COMNAVMEDCOM. The board will consist of a minimum of five members, three of whom shall be flight surgeons. The decision of the board will be final. Individuals appealing may request appearance before this board. Upon such request for appearance, the individual may be issued temporary additional duty orders authorizing Government air travel at no additional expense to the Government, in accordance with current directives.

15-81. Recording and Forwarding of Physical Examinations.

(1) When a physical examination of aviation personnel (class 1 or 2) is performed, it shall be recorded on the SF 88 in accordance with current COMNAVMEDCOM instructions. This form and the SF 93, completed in rough or smooth, shall be filed sequentially in the right side of the Health Record jacket in accordance with BUMEDINST 6150.34 series. A copy of the SF 88 and SF 93 shall be retained for 3 years at the examining facility. The results of the physical examination shall be recorded on the NAVMED 6150/2 of the examinee's Health Record jacket. In situations involving all candidates for flight training, the SF 88 must be typewritten and the original and one copy forwarded to the Navy Recruiting Command or Headquarters, Marine Corps (Code DPC), to be further forwarded to NAMI (NAMI-14) for endorsement and return to the Navy Recruiting Command or Headquarters, Marine Corps (Code DPC), and the Health Record. For those candidates who fail, the examining flight surgeon shall forward to the Navy Recruiting Command or Headquarters, Marine Corps (Code DPC) as appropriate, typewritten original and one copy of the SF 88, and in item 77 a statement regarding qualification for class 1 or class 2 aviation personnel and appointment to commissioned grade. For naval aircrewmembers and noncrewmembers, reports of physical examination shall be forwarded in accordance with a article 15-77(5)(d).

(2) In the following situations, when a physical examination is completed and recorded in the rough, the results of the examination shall be typewritten and the original of this completed report (SF 88) shall be reviewed for completeness and signed by the examining flight surgeon prior to being signed in item 82 by the reviewing authority. The complete original SF 88 is submitted to NAMI (NAMI-14) for endorsement and return to be incorporated in the Health Record when:

(a) As a result of a complete physical examination of class 1 personnel, the flight surgeon recommends a temporary (in excess of 30 days) or permanent change in service group of flying status.

(b) A report to COMNAVMECOM is specifically directed by proper authority.

(c) Naval aviation personnel, class 1 and 2 are found disqualified and the status of disqualification is expected to be in effect longer than 30 days.

(d) Naval aviation personnel who were disqualified and so reported to COMNAVMECOM are subsequently found to be qualified.

(e) An aviator of the U.S. Naval or Marine Corps Reserve reports for active duty, if such duty is expected to continue in excess of 15 days, if they have not had a qualifying aviation physical examination within the preceding 12 months and whose Health Record does not contain a COMNAVMECOM endorsed SF 88 within the preceding 3 years.

(f) A physical examination is completed for the purpose of fulfillment of the requirements of triennial or quadrennial physical examination of inactive Reserve officers.

(g) After the examination of aviation personnel of any classification, the flight surgeon or board of flight surgeons considers a review of the findings by COMNAVMECOM advisable.

(h) Class 1 and class 2 personnel have appeared before a medical board and have been found fit for full or limited duty.

(i) Any person in flight training demonstrates a visual acuity of less than 20/20 in either eye or when such person develops any other disqualifying defect which is considered permanent.

(j) A physical examination of aviation personnel is completed to fulfill the requirements of an annual physical examination on a flag or general officer, O-6 Navy or Marine Corps, or a service group III aviator who is flying in a pilot in command status by virtue of a waiver, see article 15-69(1)(c)(2).

(k) Aviation personnel are at ages 24, 27, 30, 33, 36, 39, 42, 45, and then annually, or if COMNAVMECOM's approved SF 88 is more than 3 years old prior to age 42.

(l) Any class personnel have been granted a waiver for medical reasons by an appropriate authority.

(3) When authorized, the medical officer may add the forwarding endorsement of the commanding officer "by direction." In the event, however, that the report of the physical examination contains remarks which could be construed as damaging to the examinee or recommendation which might jeopardize an examinee's career in aviation, it is mandatory that it bears the signature of the senior medical officer present. In addition, it is recommended that such situations be reviewed by the individual's commanding officer. When higher authority directs that a report of a physical examination be forwarded through a chain of command, it shall be the responsibility of that higher authority to assure arrival of the complete typewritten original and required copies of the SF 88 at NAMI (NAMI-14). This is necessary to permit COMNAVMECOM to return an endorsed physical examination to the place of examination for compliance with article 15-81(4).

(4) When an individual in aviation class 1 or 2 or a candidate for flight training is transferred from one ship or station to another, the member's current SF 88 shall be forwarded with the Health Record to the medical officer of the new ship or station. The current SF 88 is the report of the most recent physical examination which has been endorsed by COMNAVMECOM regardless of its date. A space 4 inches (10.16 cm) on the right of item 73 and item 74 shall be reserved for the required COMNAVMECOM endorsement (see art. 16-74, illustration 1c).

(5) The physical examination records of aviation personnel shall be inspected by the medical and dental officers at the annual verification of the Health Records as specified in article 16-3. If a medical or dental record is missing or incomplete, the medical or dental officer shall so inform the commanding officer, who shall direct the individual to report to the medical or dental officer for the necessary examination to complete the records.

(6) Medical Examination for Federal Aviation Administration (FAA) Certification.

(a) The senior naval flight surgeon assigned to a flight surgeon billet at a naval aviation installation listed in the current FAA directory of aviation medical examiners is authorized to perform or supervise FAA second class and third class medical examinations and issue the appropriate medical certificate to all military personnel on active duty, including active duty for training. Naval personnel whose military duties include or may include control of airtraffic (air controller, tower controlmen, etc.) must have FAA certification. The examination and issuance of medical certificates to other military personnel will be done as a courtesy, subject to the availability of time, personnel, and

facilities, and shall not be permitted to interfere with the primary duties of flight surgeons.

(b) The physical standards and administrative procedures contained in chapter 15, section V, of this Manual; the Federal Aviation Regulations, part 67, FAA Office of Aviation Medicine, "Guide for Aviation Medical Examiners"; and instructions accompanying the FAA Form 8500-8 shall apply.

(c) Disposition of Reports.-When an applicant is fully qualified by Navy and FAA standards, the appropriate FAA Medical Certification Form 8500-9 or 8420-2 shall be issued. In addition:

(1) The FAA copy of the FAA Form 8500-8 shall be sent directly to the Chief, Aeromedical Certification Branch, Department of Transportation, Federal Aviation Administration, P.O. Box 25082, Oklahoma City, OK 73125.

(2) The AME copy of the FAA Form

8500-8 shall be retained at the examining facility for 3 years, then destroyed.

(3) If COMNAVMECOM endorsement is required, the typewritten original of the SF 88 shall be forwarded to NAMI (NAMI-14).

(d) Each of the designated naval aviation installations is on the FAA distribution list for FAA Office of Aviation Medicine publications; each flight surgeon's office shall keep a current file of these publications.

(7) Sample Standard Form 88 (Aviation).-

(a) Report of Aviation Candidate Medical Examination (Front).-See article 16-74, 1B.

(b) Report of Aviation Candidate Medical Examination (Back).-See article 16-74, 1C.

(c) Report of Aviation Annual Medical Examination (Front).-See article 16-74, 1D.

(d) Report of Aviation Annual Medical Examination (Back).-See article 16-74, 1E.

Section VI. RESERVE COMPONENTS, NAVY AND MARINE CORPS

	Article
Physical Standards	15-82
Physical Examinations for Appointment, Enlistment, and Promotion	15-83
Periodic Physical Examination and Annual Certificate of Physical Condition (NAVMED 6120/3)	15-84
Physical Examinations for Active Duty and Active Duty for Training	15-85
Physical Examinations for Assignment to Organized or Selected Reserve Units, Transfer From One Organized or Selected Reserve Unit to Another, or Transfer From Standby to Ready Reserve	15-86
Examinations for Class 1 or Class 2 Aviation Personnel	15-87
Physical Defects, Reporting, and Disposition	15-88

15-82. Physical Standards

(1) The physical standards for appointment and enlistment are the same as those prescribed for the Regular Service.

(2) The physical standard for retention of personnel (officer and enlisted) is physical fitness to perform all the duties of grade, rate, and category to a degree which would reasonably fulfill the purpose of employment on active duty. Although a member may meet the standards for retention in the Naval or Marine Corps Reserve, if in the opinion

of the medical examiner the member is likely to require repeated or prolonged hospitalization or absences from work or the member presents any condition that would form the basis for a claim for disability benefits if ordered to active duty, the member should be found not physically qualified and the SF 88 and SF 93 submitted to BUMED (MED 262) for decision.

(3) The physical standards for various categories of reservists are summarized in the following table, in which the numbers refer to the notes below the table:

CATEGORY	PHYSICAL REQUIREMENTS (USNR & USMCR)	
	Officer	Enlisted
Appointment	1 & 4	—
Enlistment	—	2 & 4
Active duty and active duty for training in excess of 30 days	3	3
Active duty for training of 30 days or less and involuntary training duty for 45 days or less	3	3
Transfer to drill pay status	3	3
Promotion, inactive	3	—
Periodic and quadrennial	3	3

EXPLANATION OF NOTES

1. Must meet the physical standards for appointment in the Regular Navy or Marine Corps.
2. Must meet the physical standards for enlistment in the Regular Navy or Marine Corps.
3. Must meet the retention policy set forth in article 15-82(2).
4. A recommendation for a waiver of the physical standards may be made for appointment or enlistment in the naval service in accordance with the criteria in article 15-43.

15-83. Physical Examinations for Appointment, Enlistment, and Promotion

(1) *Appointment.*—The physical examination for appointment to commissioned grade should be conducted by medical and dental officers of the Department of Defense on active or inactive duty. The services of civilian contract physicians and civilian medical facilities may be utilized only when authorized by COMNAVMILPERSCOM or CMC, as appropriate, upon the recommendation of BUMED. Inactive Re-

serve officers desiring to apply for appointment in the *Regular Navy* or *Marine Corps* (Augmentation) must meet the physical standards set forth in section I of this chapter. The examination shall be recorded on the SF 88 and SF 93, and submitted to BUMED (MED 262) for review. (Further reference should be made to appropriate portions of the BUPERSMAN or MCO P1100.61 series.)

(2) *Enlistment.*—The physical examination of applicants for enlistment, reenlistment, or extension of enlistment may be conducted by medical and

dental officers of the Department of Defense on active or inactive duty, or by a civilian contract physician.

(3) *Promotion of Officers.*—Any officer who has undergone a physical examination that has been recorded on SF 88 and filed in the officer's Health Record will not require an additional promotion physical examination during the ensuing 12-month period, provided the officer concerned certifies by an entry on the SF 600 that there has been no significant change in condition since the date of the last valid physical examination. When required, the physical examination may be conducted by any medical officer of the Department of Defense on active or inactive duty, or by a civilian contract physician. The examination shall be recorded on an SF 88 and SF 93 and be submitted to the cognizant jurisdictional field authority for appropriate review and action. (BUPERSINST 1421.3 series refers.)

15-84. Periodic Physical Examination, Annual Certificate of Physical Condition (NAVMED 6120/3), and Quadrennial Physical Examination

(1) *Active Reservist.*—

(a) *Periodic Physical Examination.*—When not on active duty, including active duty for training in excess of 30 days, all naval Reservists of the Selected Reserve and all others in a drilling status (Ready Reservists or Standby Reserve Active (S1)) and all selected Marine Corps Reservists shall undergo a complete physical examination within 30 days of their birthdate at ages 21, 24, 27, 30, 33, 36, and annually thereafter. Reservists who require a flight physical examination shall be examined in accordance with the schedule and the standards set forth in chapter 15, section V. Submarine and diving personnel shall be examined in accordance with the standards in articles 15-32 and 15-36. Jurisdiction for the periodic physical examination is assigned to the cognizant Reserve command authority in the field. The examination may be conducted by any medical officer of the Department of Defense, on active or inactive duty, or by a civilian contract physician. The scope of the system examination shall be in accordance with article 15-53; however, unless otherwise indicated, an annual chest X-ray (except as required by articles 15-101 and 15-102) and EKG are not required until age 40. Hospitalization of an inactive reservist at a military medical facility for the purpose of physical examination or any part thereof is *not* authorized; however, outpatient consultation at military medical facilities for the purpose of determining fitness for retention and/or active duty is authorized at no expense to the Government. In those instances where a required examination or test is not conducted, this fact should be noted in the member's Health Record with the recommendation that such be accomplished incident to the member's next period of

active duty or active duty training. As part of the examination, an SF 93 shall be completed and signed by the member. The medical examiner shall comment under item 25 of the SF 93 on all affirmative answers checked by the examinee. For identification, enter "USNR TRIENNIAL" (or ANNUAL) or "USMCR TRIENNIAL" (or ANNUAL) as appropriate in item 5 on the SF 88 and 93.

(b) *Submission of Physical Examination Reports.*—Upon completion of the examination, the SF 93 and the SF 88 shall be filed in the member's Health Record. Personnel found not physically qualified, or when doubt exists as to the member's physical qualifications, current SF 88's and SF 93's consultation reports, abstracts of treatment, documented reports of lost time from gainful employment and/or student activities, and a brief summary of the effect that physical defects noted have had upon the member's performance in the Reserve unit, shall be submitted to COMNAVMEDCOM via the cognizant field authority. For flag and general officers, the original SF 88 and 93 shall be filed in the officer's Health Record and a signed copy of the SF 88 and 93 forwarded to COMNAVMEDCOM *annually*. For those physically qualified officer personnel serving in an aviation category only, the typewritten original SF 88 and 93 shall be submitted every 3 years to NAMI (NAMI-14) for review, endorsement, and subsequent return to the member's command. *No other reports of annual physical examinations are required to be submitted to COMNAVMEDCOM.*

(c) *Annual Certificate of Physical Condition (NAVMED 6120/3).*—During the years that a complete physical examination is not required in accordance with the above schedule, the commanding officer shall ensure that each member of the unit completes an Annual Certificate of Physical Condition, NAVMED 6120/3. The member is responsible for notifying the commanding officer at any time there is a change in the member's physical condition that may interfere with performance of duty in the Reserve unit. If a member answers YES to question -1, and the medical officer or commanding officer is of the opinion that the injury, illness, or disease resulting in hospitalization or absence from work or school may interfere with the member's performance of drills, active duty, or active duty for training, a complete physical examination shall be conducted; and the commanding officer shall submit copies of consultation reports, abstracts of treatment, narrative summaries, or other available medical records, and a brief summary of the effect that physical defects noted may have upon the member's performance in the Reserve unit, along with the current SF 88 and SF 93 to COMNAVMEDCOM via the cognizant field authority for review and disposition. Members answering YES to question -2, must be referred to appropriate medical authorities for evaluation of the

alleged defect, and, if indicated, the evaluation reports and current SF 88 and SF 93 submitted to NAMI (NAMI-14) via the cognizant field authority for review and disposition. *The completed NAVMED 6120/3 shall be filed in the member's Health Record.*

(2) *Inactive Reservist.*—

(a) *Quadrennial Physical Examination.*—

When not on active duty, all reservists (other than those in the Standby Reserve, selected Marine Corps Reserve or Retired Reserve, or those reservists listed above who require triennial/annual physical examination, or members of the Fleet Reserve and Fleet Marine Corps Reserve) shall be physically examined once every 4 years or more often if deemed necessary. Such 4-year period shall be considered to commence on the day following the date of completion of the last physical examination, the findings of which were reported on the SF 88. Jurisdiction for quadrennial physical examination is assigned to the cognizant Reserve command authority in the field. The examination may be conducted by any medical officer of the Department of Defense on active duty or inactive duty or by a civilian contract physician. The scope of the system examination shall be in accordance with the guidelines set forth in article 15-52. Where any part of the examination or tests is not completed, this fact shall be noted on the SF 88 prepared incident to the member's examination. As part of the examination, an SF 93 shall be completed and signed by the member. The medical examiner shall comment under item 25 of the SF 93 on all affirmative answers checked by the examinee. In view of the lapse of time between examinations, it is incumbent upon the medical examiner to describe in detail any defects or disabilities noted. For identification, enter "QUADRENNIAL" in item 5 on the SF 88 and 93. All quadrennial physical examinations shall be reported in accordance with article 15-90.

(b) *Annual Certificate of Physical Condition* (NAVMED 6120/3).—All reservists not on active duty, except Retired Reserves and members of the Fleet Reserve and Fleet Marine Corps Reserve, are required to submit an Annual Certificate of Physical Condition (NAVMED 6120/3). This shall be accomplished by members forwarding a completed and signed NAVMED 6120/3 to the appropriate jurisdictional command authority in the field. It shall be the responsibility of the cognizant jurisdictional command authority in the field to institute procedures for the fulfillment of this requirement. The completion of an SF 93 incident to a complete physical examination shall be considered as fulfilling the requirement for submission of NAVMED 6120/3 for that year. If the information on NAVMED 6120/3 indicates the possibility that a member may be unfit, the cognizant jurisdictional command authority in the field shall obtain such information as may be considered necessary to determine the mem-

ber's physical fitness for active duty and retention. Where possible, any additional tests or examination shall be obtained at an Armed Forces medical facility, on an outpatient basis; and, if obtained elsewhere they must be at no expense to the Government. NAVMED 6120/3 shall *not* be forwarded to BUMED.

(3) *Opinion or Recommendation.*—The purpose of the physical examination is to establish the physical fitness of reservists for active duty. In determining physical fitness for active duty, due consideration is to be given to the policy set forth in article 15-82(2) and to the character of the duty to which the member may be assigned if ordered to active duty. Those who are considered unfit for active duty and retention, or who may reasonably be expected to be unfit in the near future, or whose condition is such as to constitute an unwarranted high health risk if accepted for active duty, should be reported to be physically unfit for retention in the naval service. In all instances where a member is not considered physically qualified, the decision as to physical classification and disposition shall be deferred to the Navy Department via the cognizant jurisdictional command authority in the field, in order that the needs of the service may be considered in determining appropriate disposition. Medical examiners are to bear in mind the need to maintain a healthy and fit Reserve personnel force, and, therefore, those who are not considered physically qualified for retention in the Reserve should be recommended for separation. The medical examiner shall specify the type of duty to which the member is considered qualified to perform; i.e., shore duty, sea duty, field duty, or duty involving flying.

15-85. Physical Examinations for Active Duty and Active Duty for Training

(1) *Active Duty or Active Duty for Training in Excess of 30 Days.*—

(a) Members ordered to active duty or active duty for training in excess of 30 days are not required to undergo a complete physical examination prior to reporting for such duty, provided a complete physical examination was conducted within the preceding 12 months and SF 88 and SF 93 are filed in the member's Health Record. The cognizant medical officer (or in the absence of a medical officer, a Medical Department representative qualified in accordance with chapter 9, shall ascertain that there has been no significant change in the member's physical condition and that the member continues to be physically qualified to perform active duty (see art. 15-57 for scope of evaluation). Certification of continued physical fitness shall be accomplished by an entry on the SF 600 and endorsement of appropriate orders. If a current SF 88 and 93 are not in the member's Health Record, a complete examination shall be conducted prior to reporting for active duty or

active duty for training in excess of 30 days. If physically qualified, the report of examination (SF 88/93) shall be filed in the member's Health Record. Should conditions be discovered which are considered sufficient to preclude the member's reasonable performance of duty to which the member is being assigned, the medical officer shall report the findings to the member's commanding officer for appropriate action. In addition, the findings (SF 88/93) and appropriate consultation reports shall be forwarded to BUMED (MED 262) via the cognizant field authority for review and appropriate action.

(b) Members ordered to involuntary active duty shall be processed in the same manner as any member ordered to active duty (see art. 15-85(1)(a)). Those members ordered to involuntary active duty for unsatisfactory participation, who have not been physically examined during the preceding 12 months, may be ordered to undergo a physical examination prior to or upon reporting for such duty. If physically qualified, the member shall carry out the remainder of orders and the SF 88 and 93 shall be filed in the member's Health Record. If found not physically qualified, the report of the examination (SF 88/93), with appropriate consultations attached, shall be forwarded to BUMED (MED 262) via the cognizant field authority for appropriate action. The provisions of article 15-50 shall be adhered to incident to the transfer of the member to involuntary active duty for physical examination and subsequent active duty. In other words, should the member present an obviously disqualifying defect, the member's commanding officer should be so advised and orders held in abeyance pending further evaluation by the cognizant field authority.

(c) All members of the Naval and Marine Corps Reserve shall undergo a complete physical examination prior to release from active duty or active duty for training in excess of 30 days in the same manner as a member of the Regular service being separated from the active list in accordance with article 15-56.

(2) Active Duty for Training of 30 Days or Less and Involuntary Training Duty for 45 Days or Less. —

(a) Members ordered to active duty for training of 30 days or less and members ordered to involuntary training duty for 45 days or less are not required to undergo a physical examination prior to or upon reporting for such duty, provided a complete physical examination was conducted in accordance with the schedule in article 15-84 and a complete report of such examination, on SF 88 and 93, is filed in the member's Health Record. The medical officer (or in the absence of a medical officer, a Medical Department representative qualified in accordance with chapter 9) shall ascertain that there has been no significant change in the member's physical condition and that the member has not incurred a defect or disability which would preclude the reasonable per-

formance of training duty. Certification of continued fitness shall be accomplished by an entry on the SF 600 and endorsement of appropriate orders. If a complete and current SF 88 and 93 are not in the member's Health Record, a complete physical examination shall be conducted prior to or upon reporting for training duty, and recorded on SF 88 and 93 which shall be filed in the member's Health Record. The reservist must be considered physically qualified to reasonably perform the duties to which the member is to be assigned, must be free of infectious or contagious disease, and must receive, or have received, the required vaccination and inoculations. Should it be determined that the member is not physically qualified for training duty, a complete physical examination shall be conducted and reported on the SF 88. The SF 88, current SF 93, and all clinical abstracts, consultation reports, etc., shall be forwarded to BUMED (MED 262) via the cognizant field authority.

(b) Upon release from active duty for training of 30 days or less and involuntary training duty for 45 days or less, an extensive physical examination is required only if a member has suffered or alleges to have suffered a disease or injury while so employed. Where there is no question of injury or disease incurred during such training, the physical examination to be given shall be sufficient for the medical examiner to reasonably determine whether or not the health of the member has been adversely affected by the training duty. For this purpose, it should usually be sufficient for the examiner to question the member and examine any impairment that would be likely to have resulted from disease or injury to which the member was exposed during training duty. An entry to this effect shall be made on the SF 600. Members who have suffered disease or injury in the line of duty which requires treatment or hospitalization shall be given such treatment in accordance with current SECNAVINST 1770.3 series and BUMEDINST 6320.31 series.

(c) Reservists performing inactive duty training such as regular drill, etc., are to be considered physically qualified to participate, provided they are considered physically qualified for retention as a result of a complete physical examination conducted in accordance with the schedule in article 15-84(1). However, if at any time the member's commanding officer, medical officer, or Medical Department representative has reason to believe that physical unfitness exists, the reservist shall be examined to determine physical fitness. If unfitness exists, a SF 88 and 93 (with abstracts of treatment, consultation reports, etc., if indicated, attached) shall be completed and forwarded to BUMED (MED 262) via the cognizant jurisdictional field authority. It is required that all reservists performing inactive duty training receive the required vaccination and inoculations annually. An annual tuberculin skin test shall be performed on

all with no test or with negative skin tests recorded previously. Annual chest X-rays are required only for those personnel with positive tuberculin test as defined in article 15-102(3)(c), unless otherwise indicated.

15-86. Physical Examinations for Assignment to Organized or Selected Reserve Units, Transfer From One Organized or Selected Reserve Unit to Another, or Transfer From Standby to Ready Reserve

(1) *General.*—For any member who has satisfactorily undergone a complete physical examination within 1 year preceding application, an examination incident to assignment to an Organized or Selected Reserve unit, or transfer to the Ready Reserve category is not required, except for assignment concerned with duty involving flying. A physical examination incident to transfer from one Organized or Selected Reserve unit to another is not required, provided the member concerned has completed the physical examination requirements of article 15-84. The member shall execute a SF 93 to be reviewed by the cognizant medical department. If a physical examination is required, the member shall be completely examined and must meet the criteria prescribed in articles 15-82(2) and (3) before such transfer or assignment becomes effective. Applications for assignment to Organized or Selected Reserve units or for transfer to the Ready Reserve category shall be submitted in accordance with currently prescribed administrative procedures, but such applications shall not be processed until the examining facility has determined that the member is physically qualified.

(2) *Conditions Requiring SF 88 and 93.*—A current SF 88 and 93 shall be prepared and submitted to BUMED (MED 262) for determination of physical fitness for assignment or retention in all instances where an applicant for membership in an Organized or Selected Reserve unit is considered to be unfit; or there is a reasonable indication that there has been an adverse change in the physical condition of the applicant even though the member may meet the physical standards; or where the member has a dis-

ability compensation claim pending, or is in receipt of such compensation; or an officer is known to be classified as B, C, or "4" physical risk. Additionally, when a period in excess of 1 year has elapsed since an applicant's last complete examination, the applicant may be assigned or retained in the Selected Reserve unit, if determined to be physically qualified, but an SF 88 and 93 shall be sent to BUMED (MED 262) for review.

15-87. Examinations for Class 1 or Class 2 Aviation Personnel

(1) All reservists who are members of organizations under the jurisdiction of CNRESTRA or MARTC shall undergo such examinations as may be required in accordance with section V of this chapter.

15-88. Physical Defects, Reporting, and Disposition

(1) *Appointment or Enlistment.*—Physical examination of applicants for appointment to commissioned grade or enlistment shall be completed regardless of whether the member is or is not physically qualified. Reports of examination shall be submitted in accordance with the guidelines set forth elsewhere in this chapter or other applicable regulations. Appropriate recommendations regarding the applicant's physical fitness for appointment or enlistment and to perform all the duties of grade or rate on the active list shall be made in item 77 of the SF 88.

(2) *Active Duty and Retention.*—

(a) Disposition of reservists on active duty, including active duty for training in excess of 30 days who are considered physically unfit for active duty and retention on the active list, shall be processed in accordance with existing regulations for disposition of similarly disqualified Regular members.

(b) Disposition of reservists on active duty for training of 30 days or less and involuntary training duty of 45 days or less who are disabled by injury or disease, shall be processed in accordance with 10 USC 6148, as implemented by current Departmental regulations.

The first part of the document discusses the importance of maintaining accurate records of all personnel activities. It emphasizes that this is essential for ensuring the integrity of the organization's operations and for providing a clear audit trail. The document also notes that this information is sensitive and should be handled accordingly.

The second part of the document outlines the procedures for conducting personnel interviews. It provides detailed instructions on how to prepare for an interview, how to conduct the interview, and how to document the results. It also includes a section on how to handle sensitive information during the interview process.

The third part of the document discusses the importance of maintaining accurate records of all personnel activities. It emphasizes that this is essential for ensuring the integrity of the organization's operations and for providing a clear audit trail. The document also notes that this information is sensitive and should be handled accordingly.

The fourth part of the document outlines the procedures for conducting personnel interviews. It provides detailed instructions on how to prepare for an interview, how to conduct the interview, and how to document the results. It also includes a section on how to handle sensitive information during the interview process.

The fifth part of the document discusses the importance of maintaining accurate records of all personnel activities. It emphasizes that this is essential for ensuring the integrity of the organization's operations and for providing a clear audit trail. The document also notes that this information is sensitive and should be handled accordingly.

The sixth part of the document outlines the procedures for conducting personnel interviews. It provides detailed instructions on how to prepare for an interview, how to conduct the interview, and how to document the results. It also includes a section on how to handle sensitive information during the interview process.

The seventh part of the document discusses the importance of maintaining accurate records of all personnel activities. It emphasizes that this is essential for ensuring the integrity of the organization's operations and for providing a clear audit trail. The document also notes that this information is sensitive and should be handled accordingly.

The eighth part of the document outlines the procedures for conducting personnel interviews. It provides detailed instructions on how to prepare for an interview, how to conduct the interview, and how to document the results. It also includes a section on how to handle sensitive information during the interview process.

The ninth part of the document discusses the importance of maintaining accurate records of all personnel activities. It emphasizes that this is essential for ensuring the integrity of the organization's operations and for providing a clear audit trail. The document also notes that this information is sensitive and should be handled accordingly.

The tenth part of the document outlines the procedures for conducting personnel interviews. It provides detailed instructions on how to prepare for an interview, how to conduct the interview, and how to document the results. It also includes a section on how to handle sensitive information during the interview process.

The eleventh part of the document discusses the importance of maintaining accurate records of all personnel activities. It emphasizes that this is essential for ensuring the integrity of the organization's operations and for providing a clear audit trail. The document also notes that this information is sensitive and should be handled accordingly.

The twelfth part of the document outlines the procedures for conducting personnel interviews. It provides detailed instructions on how to prepare for an interview, how to conduct the interview, and how to document the results. It also includes a section on how to handle sensitive information during the interview process.

The thirteenth part of the document discusses the importance of maintaining accurate records of all personnel activities. It emphasizes that this is essential for ensuring the integrity of the organization's operations and for providing a clear audit trail. The document also notes that this information is sensitive and should be handled accordingly.

The fourteenth part of the document outlines the procedures for conducting personnel interviews. It provides detailed instructions on how to prepare for an interview, how to conduct the interview, and how to document the results. It also includes a section on how to handle sensitive information during the interview process.

The fifteenth part of the document discusses the importance of maintaining accurate records of all personnel activities. It emphasizes that this is essential for ensuring the integrity of the organization's operations and for providing a clear audit trail. The document also notes that this information is sensitive and should be handled accordingly.

The sixteenth part of the document outlines the procedures for conducting personnel interviews. It provides detailed instructions on how to prepare for an interview, how to conduct the interview, and how to document the results. It also includes a section on how to handle sensitive information during the interview process.

The seventeenth part of the document discusses the importance of maintaining accurate records of all personnel activities. It emphasizes that this is essential for ensuring the integrity of the organization's operations and for providing a clear audit trail. The document also notes that this information is sensitive and should be handled accordingly.

Section VII. REPORTING RESULTS OF PHYSICAL EXAMINATIONS

	Article
General	15-89
Disposition of SF 88 and SF 93	15-90
Validity Periods for Reports of Medical Examinations	15-91

15-89. General

(1) Standard forms for use by all medical military establishments have been adopted for the purpose of preserving and utilizing information obtained from physical examinations. Each physical examination shall be recorded on Standard Form 88 (Report of Medical Examination), and the examinee's prior or intervening medical history shall be recorded on Standard Form 93 (Report of Medical History). These forms, when completed, shall be disposed of in accordance with the guidelines in article 15-90.

15-90. Disposition of SF 88 and SF 93

(1) Specific requirements for preparation and disposition of the SF 88 and 93 in most of the major categories are tabulated on the following pages. Guidance on the number of copies (SF 88/93) and reporting of physical examinations for various special categories are outlined in other portions of this chapter (i.e., aviation, submarine, divers, antarctic, etc.).

15-91. Validity Periods for Reports of Medical Examinations

(1) A medical examination will be valid for the purpose and within the periods set forth below pro-

vided there has been no significant change in the member's physical or medical condition.

(a) One year from date of medical examination to qualify for induction, enlistment, appointment as a Reserve or Regular officer, and enrollment in officer candidate programs.

(b) Six months from date of examination for separation from active duty including retirement. Members being processed for physical disability retirement are exempt from this requirement.

(c) Ninety days from date of medical examination for separation from active duty for former members desiring to reenlist in naval service. The copy of the former member's separation physical examination (SF 88) given at time of release must be presented to the recruiting office for review of item 77, to determine if the former member was, in fact, fit for separation and/or reenlistment.

(2) A medical examination conducted for one purpose is valid for any other purpose within the prescribed validity periods provided the examination is of the proper scope specified elsewhere in this chapter or other regulations. If the examination is deficient in scope, only those tests and procedures needed to meet the additional requirements need be accomplished and the results recorded.

Preparation and Disposition of Report of Medical Examination (SF 88) and Report of Medical History (SF 93)

Note—Health Record abbreviated HR

I T E M	Purpose of examination	Standard Form 88, number needed and disposition				Standard Form 93, number needed and disposition			
		Physically qualified		Disposition		Physically qualified		Disposition	
		If YES, copies*	If NO, copies*	Original	Copy	If YES, copies*	If NO, copies*	Original	Copy
		NAVY AND MARINE CORPS OFFICER CANDIDATE PROGRAMS (See Note ¹)							
1.	AOC, NFOC, NAOC—AI; enrollment.	3.		NRC (311)		2.		NRC (311)	
2.	ACC, NFOC, NAOC—AI; retention & precom- missioning.	3.		NRC (311)		2.		NRC (311)	
3.	Direct appointment; USN, USNR.	2.		NRC (3123)		1.		NRC (3123)	
4.	OCS, male and female applicants	2.		NRC (3123)		1.		NRC (3123)	
5.	Ensign 19xx, all programs	2.		NRC (3141)		1.		NRC (3141)	
6.	LDO; application for appointment	See BUPERSMAN 1020290				See BUPERSMAN 1020290			
7.	WO; application for appointment	See BUPERSMAN 1020310				See BUPERSMAN 1020310			
8.	LDO & WO; precommissioning	See BUPERSMAN 1020180				See BUPERSMAN 1020180			
9.	Merchant Marine Academy graduates; pre- commissioning.	2.		NRC (3141)		1.		NRC (3141)	
10.	Merchant Marine Academy, midshipmen appointment.	See BUMEDINST 6120.3 series				See BUMEDINST 6120.3 series			
11.	U.S. Naval Academy applicants	See BUMEDINST 6120.3 series				See BUMEDINST 6120.3 series			
12.	U.S. Naval Academy graduates; precom- missioning.	2.		NRC (313)		2.		NRC (313)	HR
13.	Project Boost	1.		NRC (314)		1.		NRC (314)	
14.	NESEP; precommissioning.	3.		NMPC (211)		2.		NMPC (211)	
15.	NESEP; NROTC, retention	See art. 15—54.				See art. 15—54.			
16.	NROTC (Scholarship) enrollment	See BUMEDINST 6120.3 series				See BUMEDINST 6120.3 series			
17.	NROTC (College) enrollment	2.		BUMED (MED 262)		1.		BUMED (MED 262)	
18.	NROTC; precommissioning	2.		BUMED (MED 262)		1.		BUMED (MED 262)	

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19. NROTC; ENTPF and FIP	2	NAMI (NAMI-14)	1	NAMI (NAMI-14)
20. NUPOC, Surface and Submarine	2	NRC (3123)	1	NRC (3123)
21. OCS graduates; precommissioning	2	HR	1	HR
	3	NRC (3123)	HR	2
22. Regular Navy Augmentation Program	See BUPERSMAN 1020120	See BUPERSMAN 1020120		
23. AVROCTWO enrollment 1395 or 1355	2	NRC (311)	2	NRC (311)
24. ROC TWO enrollment and ROC ONE; precommissioning.	2	NRC (3141)	1	NRC (3141)
25. AVROC (1395 or 1355) ROC; precommissioning.	2	NRC (311)	2	NRC (311)
26. Marine OCC; AOC; ECP; OMCR; enrollment	3	CMC (MMRE-31)	3	CMC (MMRE-31)
27. Marine LDO or WO; appointment.	3	CMC (MMRE-6)	HR	3
28. Marine PLC; enrollment	3	CMC (MMRE-32M)	3	CMC (MMRE-32M)
29. Marine WOCC; enrollment	3	CMC (MMRE-33)	3	CMC (MMRE-33)
30. WOCC; precommissioning	3	HR	3	HR
	3	CMC (MMRE-33)	2	CMC (MMRE-33)
31. PLC; precommissioning	3	CMC (MMRE-32G)	3	CMC (MMRE-32G)
32. Regular Marine Corps Augmentation Program	3	CMC (MMRE-6)	HR	3

ENLISTMENT AND REENLISTMENT

33. USN, USMC, original enlistment; USNR, USMCR, original enlistment for immediate active duty.	3	Note 2	2	Note 2
	2	Note 3	1	Note 3
34. USNR & USMCR original enlistment all classifications not for immediate active duty.	3	Note 2	2	Note 2
	2	Note 3	1	Note 3
35. USN, USMC, immediate reenlistment or extension of enlistment; USNR, USMCR, immediate reenlistment or extension of enlistment while on active duty.	1	HR	0	
	1	HR	0	
		(Refer instances of NPQ to medical board.)		

* Includes original.

See notes at end of table.

Preparation and Disposition of Report of Medical Examination (SF 88) and Report of Medical History (SF 93)—Continued

Note—Health Record abbreviated HR

I T E M	Purpose of examination	Standard Form 88, number needed and disposition				Standard Form 93, number needed and disposition			
		Physically qualified		Disposition		Physically qualified		Disposition	
		If YES, copies*	If NO, copies*	Original	Copy	If YES, copies*	If NO, copies*	Original	Copy
ENLISTMENT AND REENLISTMENT—Continued									
36. USN, USMC reenlistment with broken service	3			Note 2		2		Note 2	
				Note 3		1		Note 3	
37. USNR, USMCR reenlistment or extension of enlistment while not on active duty.	1			HR		1		HR	
				HR	BUMED (MED 262)	2		HR	BUMED (MED 262)
MISCELLANEOUS									
38. Preretirement, active duty officers:									
NAVY	2			HR	NMPC (23)	0			
		0		Not required (See art. 15-56.)		0			
MARINE CORPS	2			HR	CMC (MMSE)	0			
		0		Not required (See art. 15-56.)		0			
39. Transfer to Fleet Naval Reserve or Fleet Marine Corps Reserve.	2			HR	See Note 5	0			
		0		Not required (See art. 15-56(4).)					
40. Promotion, active duty, USN, USNR, USMC, USMCR.	See art. 15-59					See art. 15-55			
41. Promotion, inactive duty, USNR, USMCR.	See art. 15-83 (3)					See art. 15-83 (3)			
42. Separation from active duty, discharge or retired.	2			HR	Member	0			
		0		Not required (See art. 15-56(2).)		0			
43. Triennial/annual, officer, active duty (USN, USNR, USMC, USMCR).	See art. 15-52					See art. 15-52			

44. Annual—certain enlisted members, active duty, USN, USNR, USMC, USMCR.	See art. 15-53.	See art. 15-53.	
45. Periodic, inactive duty, USNR and USMCR, officer and enlisted.	1. HR (See note 4)	1. HR	
	2. HR	BUMED (MED 262) via cognizant field authority.	2. HR BUMED (MED 262) via cognizant field authority.
46. Quadrennial, USNR, USMCR, USNFR, USMCFR, officer and enlisted.	1. Cognizant field authority	1. Cognizant field.	
	1. do.	1. do.	
47. Active duty or active duty for training for more than 30 days, USNR, USMCR, officer and enlisted.	See art. 15-85(1)	See art. 15-85(1)	
48. Release from active duty or active duty for training of more than 30 days, USNR, USMCR, officer and enlisted.	2. HR	See Note 5 . 0.	
49. Active duty for training of 30 days or less and involuntary training duty of 45 days; USNR, USMCR, officer and enlisted.	0. Not required except as set forth in art. 15-85(2)(a).	0. Not required except as set forth in art. 15-85(2)(a).	
	2. HR	BUMED (MED 262) via cognizant field authority.	2. HR BUMED (MED 262) via cognizant field authority.
50. Release from active duty for training of 30 days or less and involuntary training duty of 45 days; USNR, USMCR, officer and enlisted.	0. Not required except as set forth in art. 15-85(2)(b).	0. Not required except as set forth in art. 15-85(2)(b).	
	2. HR	BUMED (MED 262) via cognizant field authority.	2. HR BUMED (MED 262) via cognizant field authority.
51. Inactive duty training; USNR, USMCR, officer and enlisted.	0. Not required except as set forth in art. 15-85(2)(c).	0. Not required except as set forth in art. 15-85(2)(c).	
	2. HR	BUMED (MED 262) via cognizant field authority.	2. HR BUMED (MED 262) via cognizant field authority.
52. Request for assignment to Organized or Selected Reserve Units or transfer from Standby to Ready Reserve; USNR, USMCR, officer and enlisted.	See art. 15-86.	See art. 15-86.	

* To include original.
See notes at end of table.

Preparation and Disposition of Report of Medical Examination (SF 88) and Report of Medical History (SF 93)—Continued

EXPLANATION OF NOTES

Note Number	Explanation
1.	Except where otherwise indicated, the original and all copies of the SF 88 and SF 93, physically qualified or not physically qualified, are to be forwarded to the designated NRC, COMNAVMILPERSCOM, MARCORPS, or BUMED Code. NRC—Naval Recruiting Command, 4015 Wilson Blvd., Arlington, VA 22203. COMNAVMILPERSCOM—Commander, Naval Military Personnel Command, Department of the Navy, Washington, D.C. 20380. CMC—Commandant of the Marine Corps, Headquarters Marine Corps, Washington, D.C. 20380. BUMED—Chief, Bureau of Medicine and Surgery (MED 262), Department of the Navy, Washington, D.C. 20372.
2.	Original SF 88 and SF 93 attached to enlistment contract and forwarded with other enlistment documents to COMNAVMILPERSCOM or MARCORPS, as appropriate. Copy to be used to open new Health Record. (Also see art. 15-91.)
3.	Not required by BUMED, COMNAVMILPERSCOM, or MARCORPS except when waiver of physical standards is recommended, then forward to COMNAV MILPERSCOM or MARCORPS, via BUMED (MED 262). Otherwise retain in local files for 1 year, then destroy. (Also see art. 15-3(3).)
4.	See article 15-84(1)(a) for exceptions.
5.	A copy of the release SF 88 and a copy of the most recent SF 93 shall be delivered to the commanding officer for transmittal with the service record.

Section VIII. METHODS OF EXAMINATION

	Article
General	15-92
Testing Visual Acuity	15-93
Testing Heterophoria and Prism Divergence at Near and Far	15-94
Armed Forces Vision Tester (AFVT)	15-95
Depth Perception	15-96
Color Vision Testing	15-97
Examination of Heart and Blood Vessels	15-98
Examination of Range of Motion	15-99
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Roentgenographic Examination of Chest	15-101
Tuberculin Testing of Navy and Marine Corps Personnel First Reporting for Duty in Excess of 30 Days	15-102
Testing Intraocular Tension	15-103
Eustachian Tube Patency Test (Valsalva's Maneuver Modified)	15-104
Special Examination Requirements	15-105

15-92. General

(1) This section presents more detailed methods of examination which could not conveniently be included in the section on physical standards. The Army-Navy-National Research Council Vision Committee has prepared two manuals for use by all military services. One is entitled "Manual of Instructions for Testing Visual Acuity," the other "Manual for Testing Heterophoria and Prism Divergence at Near." The contents of these manuals are incorporated in articles 15-93 and 15-94 (1) and (2).

(2) Instructions for administration, scoring, and operation of the Farnsworth Lantern Test for color vision testing are engraved on a metal plate that is permanently attached to the instrument (referred to as "Lantern"). These instructions, together with improved techniques for administering the test, are in article 15-97.

15-93. Testing Visual Acuity

(1) *General.*—Visual defects are one of the major causes for physical disqualifications from the Armed Services of the United States. Methods of testing vision have varied greatly among the services and from place to place in each service. In consequence, visual test results are not comparable. A candidate presenting for examination at one center might be qualified for visual acuity while at another the candidate would be disqualified. The purpose of this article is to describe the conditions and facilities necessary and the procedure to be followed in order to correct this situation. The procedures outlined in this article are to be followed by every person who administers visual tests. It shall be the duty of the medical officer in charge to supervise and inspect the proper administration of procedures outlined in this article.

(2) *The Examination.*—(a) *Necessary Conditions.*—

(1) *Physical Equipment.*—Tests shall be given in a room where arrangements, charts, and illumination are in good order and conform as closely as possible to subarticle 15-93(3). It should be noted that, if projector charts and screens are used, the color of the walls and the arrangement of room lighting need not conform, provided the room can be darkened.

(2) *Condition of Candidates.*—Every effort should be made to examine candidates who are in normal physical condition.

(b) *Testing Acuity for Distant Vision.*—(1) *Procedure.*—

(a) If the candidate wears glasses, they must be removed before entering the examining room. Each candidate shall be tested without unnecessary delay after entering the room. To prevent personnel from memorizing the charts, only one candidate shall be permitted to view the targets at a time. Candidates awaiting test must be kept out of hearing.

(b) The candidate is directed to the indicated 20-foot (7 m) mark. The examiner holds the occluder (see drawing) and covers the candidate's left eye, while instructing the candidate to keep both eyes open without squinting. The occluder must not be permitted to touch any part of the eye to be shielded, but should be held in contact with the side of the nose.

(c) The candidate is directed to begin with the first (visible) line and to read as many lines as possible. (The larger and less used lines should be kept covered in accordance with the suggestions in subarticle 15-93(3)(c).)

(d) The smallest line read on the chart from the 20-foot (7 m) distance shall be recorded as the vision for the right eye (O.D.) in accordance with regulations in effect.

(e) The acuity for the left eye (O.S.) is then tested, using a different chart and recorded in the same manner.

(f) Finally, the visual acuity for both eyes (O.U.) may be taken, if regulations require it, with a third chart and recorded.

(g) A candidate who normally wears glasses all the time is tested again with them in place. The same procedure is followed as without glasses, for right eye, left eye, and both eyes, changing charts for each test.

(h) When there is suspicion that the candidate has memorized the charts, the candidate is to be directed to read the letters of targets in reverse order or will be shown a different chart. When suspicion still remains, the candidate should be referred to the medical officer in charge.

(i) The candidate is expected to read the letters promptly. No precise time limit should be applied but 1 or 2 seconds per letter is ample time.

(j) When a letter or target is failed, the candidate should be asked to read it again. If the candidate is a rapid reader and mistakes are obviously careless ones, the candidate should be cautioned to "slow down" and the test should be repeated on another chart.

(k) Some people give up easily. They may need encouragement to do their best. However, no coaching shall be given by the examiner.

(2) *Score Recording.*—

(a) Vision is recorded in the form of a fraction (see subarticle 15-93(4)(b)).

(b) When glasses are worn the record should read as follows:

<i>Without glasses</i>	<i>With glasses</i>
O.D. 20/	O.D. 20/
O.S. 20/	O.S. 20/
O.U. 20/	O.U. 20/

(3) *Suggested Useful Phrases for Use by Examiner.*—

(a) "Please stand here (indicating the place). Hold your head still and straight. Keep both eyes open when I cover your left eye."

(b) "When I cover your eye, don't close it, for that interferes with the test."

(c) "Start at the top and read as many lines as you can."

(d) "Don't squint. Don't screw up your eyelids or frown."

(e) "Look straight ahead."

(f) "Don't rub your eyes."

(g) "Read promptly—too much effort will tire your eyes and make it harder."

(h) "Don't hurry—get each one right that you can because you won't have another chance."

(i) "The next line may be hard but try it anyway."

(j) "If you're not quite sure, make a guess—play your hunches."

(4) *Precautions To Be Observed on Conducting Tests for Visual Acuity.*—

(a) It may be extremely difficult to obtain an accurate measure of visual acuity. The examiner must bear in mind that people who are anxious to pass tests of visual acuity will resort to deception. Similarly, others may take any means in order to fail a visual test when undesirable duties are in prospect. Hence, the examiner must be prepared to cope with either possibility so that visual defects can be uncovered and recognized without the obvious cooperation of the person being tested. If the examiner is not a medical officer, such examinees should be referred to one. Various tests for malingering are described in the Flight Surgeon's Handbook or the Aviation Medicine Technician's Manual.

(b) The examiner must watch the candidate, not the chart which is being read. The occluder must be held in such a manner that the candidate cannot peep around it. The most frequently used method of increasing visual acuity is to squint with the eyelids (screw up the eyelids). This is not to be permitted. Some people with astigmatism will be able to read the letters better by tilting the head to one side; do not allow them to do this.

(c) Another well known method used to pass a test for visual acuity is to obtain eyedrops beforehand which contract the pupil. If the pupils are unusually small, the attention of the medical officer must be called to the fact.

(d) The occluder must not be pressed against the eyeball or lids, but rather it should be held against the side of the nose. The eye shielded by the occluder should be open in order to avoid pressure and to discourage squinting.

(e) Some people may appear to be malingering when they are not, and, on the other hand, the most innocent—appearing person may be the worst malingeringer. If malingering is suspected, the candidate should be referred to the medical officer at once.

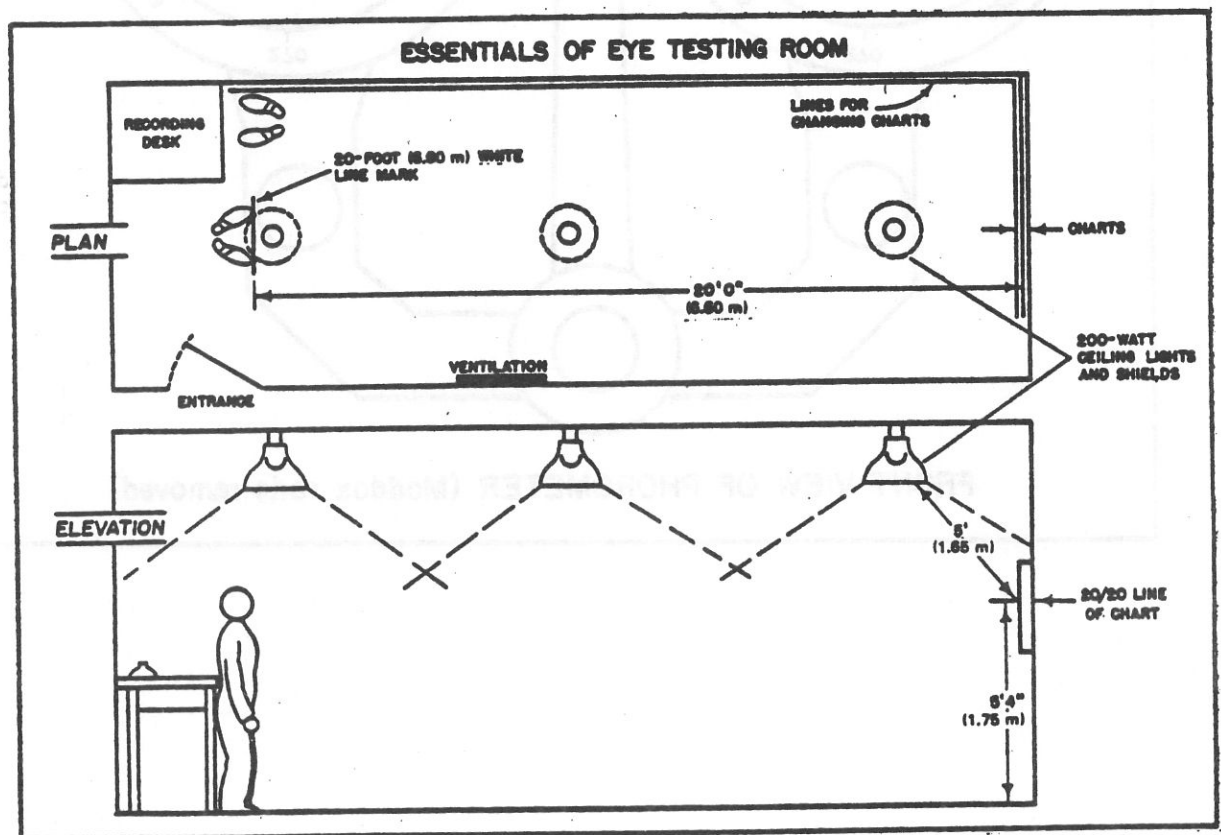
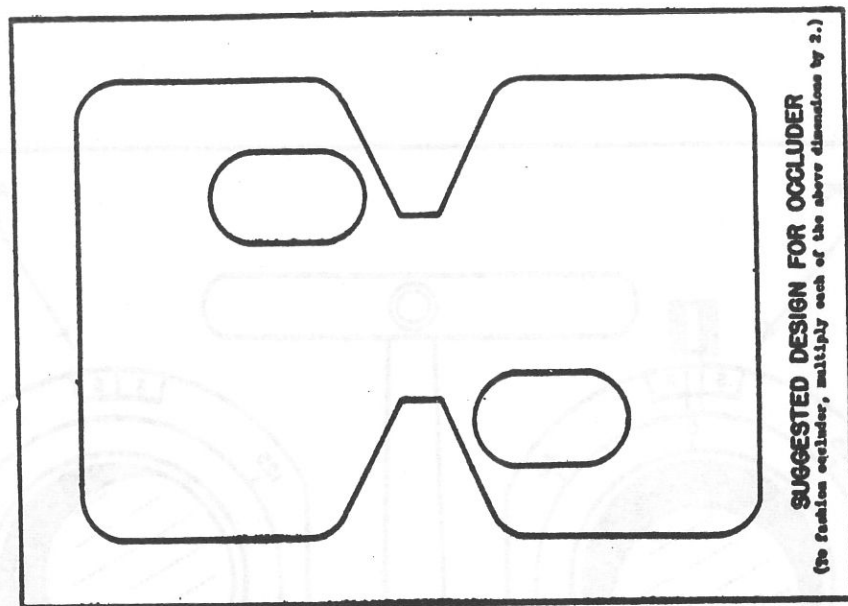
(5) *The Examiner.*—

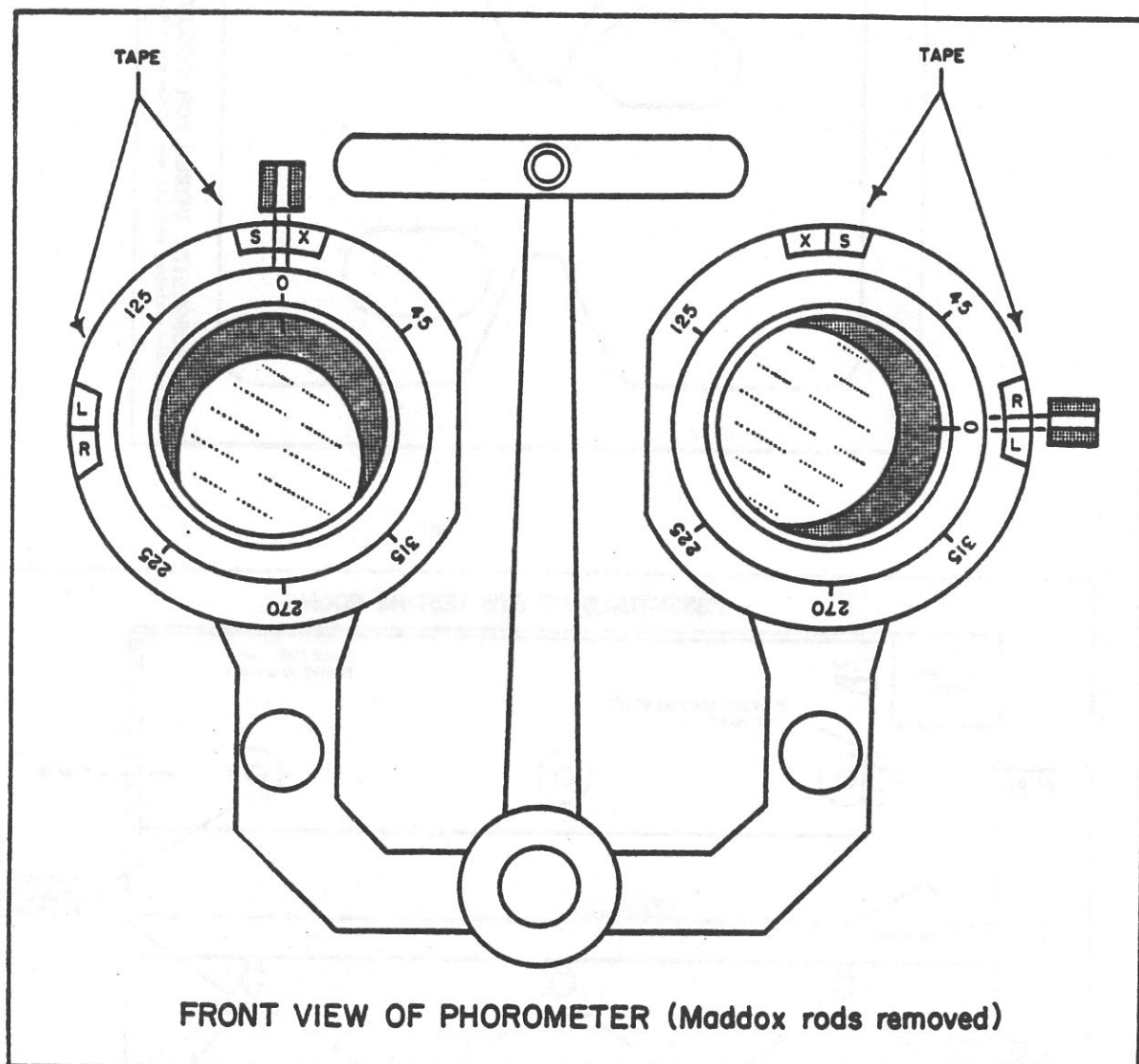
(a) The examiner must be neat in uniform and professional in manner.

(b) Test results determine the duties to which personnel will be assigned; therefore, too much care cannot be taken in tests for visual acuity if every person is to be utilized to the best purpose.

(c) The examiner must be unhurried and persevering if accurate results are to be secured. A patient, tolerant, and painstaking attitude on the part of the examiner will reassure the candidate and increase the accuracy of the visual acuity test. Haste and irritation are to be avoided.

(d) The examiner should undertake to memorize the test targets. If necessary, the examiner may hold a small card on which the targets are reproduced, in order to verify the responses. In





any event, some accurate check of the responses should be made.

(e) The routine of examination must be followed carefully in the order described. The vision for each eye should be recorded as soon as it is determined so that errors and omissions will be avoided.

(c) *Retests.*—

(1) The effects of fatigue and alcohol may make a certain amount of retesting necessary. In questionable situations, one retest shall be given not less than the day after the initial test.

(2) Occasionally an excuse is given for failure to pass the test due to temporary injury to the eyes. Examples are: that the candidate has gotten something in one or both eyes, or has been exposed to welding flash, to bright sun, etc. Such instances are to be referred to the medical officer.

(3) *Testing Room and Equipment.*—(See also art. 15-93(2)(a)(1).)

(a) *The Room.*—

(1) *Size.*—The room used for testing visual acuity must provide a distance of 20 feet (7 m) between the eyes of the person being examined and the targets. (See drawing.)

(2) *Equipment.*—A desk, stand, or high shelf shall be placed so that the examiner can observe the candidate while recording the responses. The 20-foot (7 m) mark must be carefully measured and clearly marked. (See room plan.)

(3) *Ventilation.*—Provision must be made for adequate ventilation of the testing room. This is of paramount importance.

(4) *Color.*—Walls shall be painted with flat Navy Number 9 Pearl Gray (reflectivity 46 percent) paint. Walls must not be black. Ceilings shall be painted white in order to approximate 75 percent of reflection. It is important that the trim, frame, or panel on which the charts may be mounted should be painted a gray which is not darker than the walls. The general room trim, casings, etc., shall be painted with semi-gloss Navy Number 19 Light Navy Gray (reflectivity 28 percent) paint. The standard Navy number paints referred to in this paragraph are those listed in the Navy Department manual, "The Application of Color to Shore Establishment." Windows and glass doors shall be completely covered or curtained with material which is not in contrast with the color of the walls.

(5) *Security.*—When the room is unused, there must be no access to the targets by persons who might profit by memorizing them.

(b) *Illumination.*—

(1) *Room Brightness.*—The brightness of the walls of the testing room at head height shall be not less than 3-foot (1 m) lamberts nor greater than the brightness of the test charts. Light from fixtures or openings must be shielded so that it does not shine in the candidate's eyes. There must be no glare sources or areas of high contrast in the field of view

around the test charts. The quality of light is immaterial; Mazda incandescent, or fluorescent is suitable.

(2) *Target Brightness.*—The brightness of the charts shall average 12-foot (4 m) lamberts and shall be not less than 10— or more than 15-foot (3 m or more than 5 m) lamberts. Under no circumstances shall there be shadows or reflections visible on the charts.

(3) *Lighting the Room.*—

(a) If means are not available for measuring foot-lamberts of brightness, the room should be painted as directed in subarticle 15-93(3)(a)(4), and lighted as described in the following subarticle. The brightness of the chart and walls will then approximate the requirements of 12— and 4-foot (4 m and 1 m) lamberts, respectively.

(b) A room is assumed about 24 feet long, 8 feet wide, and 10 feet high (8 m long, 3 m wide, and 3 m high) as shown in the illustrated room plan. Such a room should be lighted by three 200-watt incandescent lamps placed at a height of about 9 feet (3 m) from the floor. One lamp may be over or just behind the examinee's head. One lamp should be approximately in the middle of the room. One lamp should be exactly 5 feet (152 cm) diagonally from the 20/20 line of the chart and incident upon this part of the chart at an angle of 45° (i.e., 3½ feet (107 cm) above the 20/20 line and 3½ feet (107 cm) in front of it). All lamps must be shielded from the direct vision of the examinee by opal shades (not clear glass) or metal reflectors; or a 4-inch (10.16 cm) strip of tin can be nailed to the ceiling in front of each lamp so as to accomplish the same purpose.

(c) *Test Charts.*—

(1) At least three charts must be available. As rapidly as they are made available, only targets approved by the Army-Navy-National Research Council Vision Committee shall be used.

(2) In order to conserve the examiners' time and prevent immediate recognition of the charts which may have been memorized, the large letters above 20/30 normally may be covered by a white cardboard which can be swung aside or pulled up with a cord when it is necessary to use the larger test targets.

(d) *Occluder.*—A rigid occluder, constructed of a material such as wood, translucent plastic, or metal shall be provided to shield the eye not being tested. An excellent design to discourage cheating is illustrated.

(4) *Score Reading.*—

(a) Test charts or targets approved by the Army-Navy-National Research Council Vision Committee will replace vision testing charts presently in use as rapidly as they become available.

(b) *Permanent Reporting of Test Scores.*—Vision test scores shall be expressed as a fraction in which the upper number is the distance in feet from the targets, and the lower number is the value of the

smallest test-chart line read correctly. Thus a person reading at a distance of 20 feet (7 m) the 30-foot (10 m) test-chart line is given a score of 20/30. The indication is 20/20 when a person reads at a distance of 20 feet (7 m) the test-chart marked 20. Similarly, 20/200 means a person reads at a distance of 20 feet (7 m) only the test-chart line marked 200.

(5) *Binocular Visual Efficiency (BVE).*—BVE is a system that considers the visual acuity of both eyes rather than each eye individually and is indicated in percentages. For method of determination and standards for qualifications, refer to article 15-14(4).

15-94. Testing Heterophoria and Prism Divergence at Near and Far

(1) TESTING HETEROPHORIA.—

(a) *General.*—Heterophoria is a condition in which the eyes have a constant tendency to deviate but are prevented from so doing by fusion. When a person looks at an object, an image of that object is formed separately in both the right and the left eye. These separate images are sent to the brain where they are associated and interpreted as a single image; this process is known as fusion. Fusion is responsible for the two eyes working together in harmony and when anything prevents this, fusion is disrupted and one eye deviates. Since heterophoria is only a tendency of the eyes to deviate, no actual deviation is apparent when the eyes are being used together under ordinary conditions. The deviation becomes visible only when fusion control is weakened or abolished. When deviation occurs, its exact amount can be estimated with some accuracy by neutralizing the deviation with prisms of varying strength. If the deviating eye turns in (toward its fellow), the deviation is known as *esophoria*; if it turns out (away from its fellow), the deviation is known as *exophoria*; if the deviating eye turns up or down, the deviation is called *hyperphoria* or *bypophoria*, respectively.

(1) *Breaking up Fusion.*—For the purpose of heterophoria measurement, fusion can be disrupted by placing a Maddox rod in front of one eye. The image of a spot of light, when viewed through a Maddox rod, is converted into a line of light. When the two eyes see unlike images of the same object (one eye sees a spot of light while the other eye, the one behind the Maddox rod, sees a line of light), this disrupts fusion and tends to prevent the two eyes from working together. Thus, when heterophoria is present, one eye (the eye behind the Maddox rod) will deviate when its fellow eye continues to look at or fixate the spot of light.

(2) *Standardization of the Test.*—The measurement of heterophoria is one of the most difficult problems that the inexperienced examiner can meet. The reason is simple. There are many factors which influence the test and only a few of these are actually known. For example, it is just as important to have the examinee seated comfortably during

the test so that neck muscles are not strained as it is to have the testing equipment in good condition. Strained positions of the head and neck have a definite effect upon the measurement of heterophoria. Unless the test is performed in exactly the same way at every testing station, an examinee may pass the test at one station on one day and fail it on the next day at another station. A uniform standardized testing technique must be used at every station. This article has for its purpose the description of the testing technique to be followed at all testing stations.

(b) *Necessary Equipment.*—

(1) A testing room long enough to provide a distance of 20 feet (7 m) between the muscle light and the eyes of the seated examinee.

(2) A comfortable testing chair located at one end of the room.

(3) A muscle light (spot of light), 1 centimeter in diameter, placed at a distance of 20 feet (7 m) from the eyes of the seated examinee and facing the examinee.

(4) An ophthalmoscope with a removable, May-type head.

(5) Either (a) a binocular phorometer with Risley rotary prisms, white Maddox rods, and Stevens phorometer (graduated in tenths of a prism diopter from 0 to 2.0 attached); or (b) a monocular, portable phorometer with a Risley rotary prism and white Maddox rod attached; or (c) a trial frame with a white Maddox rod and graduated and accurately calibrated prisms, either loose or arranged vertically in a prism bar.

(6) Some method of measuring exactly 13 inches (33.02 cm) from the front of the phorometer. A cord tied to the phorometer and either looped or knotted at the proper length is satisfactory. Some phorometers have a metal rod attached to which a small light may be fixed in order to accurately measure heterophoria at 13 inches (33.02 cm).

(c) *Testing With the Binocular Phorometer.*—

(1) *Seating the Examinee.*—The examinee should first be comfortably seated in a chair. A straight backed chair with arms is preferable to a stool. If there is a head rest on the chair, it should be accurately and comfortably adjusted.

(2) *Adjusting the Phorometer.*—The phorometer should be carefully adjusted to the examinee, not the examinee to the phorometer. The examinee should never be told to "come forward a little," to "stretch your neck a bit," or "move your head sideways (to right or left) a little bit." The examiner must make these adjustments with the various controls on the phorometer; that is why they are there. (See drawing.) Don't make the examinee adjust the body to the phorometer. Adjusting the phorometer means several things. It means:

(a) Having the entire length of the browpiece touching the examinee's forehead and exerting gentle but firm pressure.

(b) Having the bubble in the spirit level accurately centered between the two markers.

(c) Having the interpupillary distance reading set on the scale and the phorometer high enough so that each of the examinee's pupils is exactly centered behind its respective frame.

(d) Having the examinee so seated and the phorometer so placed that both are exactly and directly facing the muscle light across the room.

(e) Having the equivalent of the examinee's lenses inserted in the phorometer if the examinee wears glasses all the time. If prisms are incorporated in the examinee's regular glasses, these must be omitted from the lenses inserted in the phorometer. If the examinee wears glasses all the time, any measurement of heterophoria without glasses is utterly worthless and entirely undependable.

(3) *The Maddox Rod.*—The examinee's attention is directed to the muscle light which is a spot of light 1 cm in diameter located at a distance of 20 feet (7 m) across the room. To ensure seeing it, the examiner should flash it on and off a time or two by means of a remote control switch located conveniently near at hand, if this is available. There must be no other sources of light except the muscle light visible to the examinee. There may be other lights in the room as long as the examinee cannot see them. All reflecting surfaces should also be removed from the examinee's range of vision. If this is not done, the overhead light which the examinee cannot see directly may nevertheless be reflected into the eyes from any shiny metal or glass objects in the room. If this reflection occurs, more than a single line is liable to be seen through the Maddox rod and will prove to be a disturbing factor if not a source of actual error in the test. Once the examinee has definitely located the muscle light, a white multiple Maddox rod attached to the phorometer should be rotated into position. This means rotating it on its hinge as far as it will go. It should be placed before the right eye. The axes of the small rods which make up the multiple Maddox rod should be in the horizontal meridian. With the rod in this position, when the examinee looks at the muscle light, a vertical white line is seen with the right eye (which has the Maddox rod in front of it) and a spot of light with the left eye. The examinee is thus seeing unlike images of the same object, i.e., the spot of light. The examinee should now be specifically questioned as to whether both the vertical white line of light and a white spot of light are seen. If they are, the testing may proceed. If the examinee does not see both the line and light at the same time, one of several things may have happened:

(a) The phorometer frames may not be exactly centered before each eye.

(b) Although properly centered, the phorometer may not be aimed exactly at the light.

(c) The examinee may have closed one eye. Both eyes must be kept open at all times during the test.

(d) The examinee may be unconsciously suppressing vision in one eye (see subarticle 15-94(1)(c)(4)).

(e) Visual acuity may be poor in one eye.

(f) One eye may be turned far in or far out; if one eye is deviating a great deal ("cross-eyed" or "wall-eyed"), this fact should have been noted on external examination. The presence of a manifest deviation is known as heterotropia, and no heterophoria measurement is accurate or is usually even possible.

(4) *Suppression.*—Double vision is usually avoided by the natural impulse to line up the two eyes so that they work together. In the presence of heterophoria, the examinee fuses the two images into one but to do this requires effort (whether aware of it or not). If the required effort is too great, one of the two images may be ignored by the brain and when this happens, it is known as suppression. In the use of the Maddox rod test, it is somewhat annoying to look at a spot of light, yet see a line of light with one eye and a spot of light with the other. The image of the line is often suppressed (ignored) by the brain, which means that it seems to fade in brightness and may disappear entirely. If the examinee sees only the line, or only the light, or the line and then the light alternately, it may be assumed that the examinee is suppressing, provided:

(a) The phorometer is properly adjusted.

(b) Visual acuity is normal or anywhere near equal in the two eyes.

(c) There is no gross deviation of the eyes on external examination (inspection).

If the examinee sees only the spot of light (using the left eye), the left eyepiece of the phorometer should be covered with an occluder until the light is seen by the right eye. If the cover is then removed, the line and light will usually be seen simultaneously. Likewise, if only the line is seen (using the right eye, which has the Maddox rod in front of it), the occluder should be placed over the right eyepiece of the phorometer until the spot of light is seen by the left eye. It may then be removed.

(5) *The Risley Rotary Prism.*—Once the examinee sees the line and light simultaneously, the next step is the removal of the Maddox rod from its position before the eye and the rotation of the Risley rotary prism attached to the phorometer into position before the right eye. It will be noted that its location is behind the Maddox rod, between the Maddox rod and the examinee's eye. The handle of the rotary prism should be rotated into the vertical

position (at 90°). By means of this same handle, the line indicating the position of the prism base should be rotated on or near zero. Some of the older phorometers have the handle so placed that it is to one side when horizontal muscle balance is being tested. Others have it at an angle. The proper position should be determined by the examiner beforehand.

(a) *Marking the Prism.*—

(1) It is a difficult problem for the inexperienced examiner to remember whether prism base indicates exophoria, prism base down hyperphoria, etc. For this reason, a very simple and practical solution may be found in the use of a little adhesive tape. One piece should be stuck on the fixed frame of the rotary prism over the 90° mark, and another over the 180° mark on the right eyepiece and over the 0° mark on the left eyepiece. With pen and ink, a line representing the 3 marks which have been covered should be drawn. (See drawing.) On the tape over the 90° mark on the prism before the right eye, the letter "X" should be printed on the tape on the side of the line toward the nose; similarly, a letter "S" may be printed on the opposite side of the line (toward the temple). When heterophoria is being measured, if the prism base marker is set on the "X" side of the 90° mark, exophoria is present (prism base in); if the marker has been set on the "S" side, esophoria is present (prism base out).

(2) In the same manner, the tape at 180° and at 0° can be lined. Above the line on the right prism, print the letter "L" and below the line the letter "R." When vertical heterophoria is being tested and the rotary prism handle is set at 180° (right eye), if the prism marker has been set above the line (in the "L" area), then left hyperphoria is present. If the marker has been set below the line (in the "R" area), then right hyperphoria is present. This is true for the right eye. For the left eye, as is shown in the diagram, all markings are reversed.

(b) *Instructions to the Examinee.*—

(1) Assured that the examinee sees both the line of light (seen through the Maddox rod) and the spot of light, the examiner is ready to begin the test. Since the examiner adjusts the Risley prism, the examinee need only be instructed to tell the examiner when the line of light runs through or bisects the spot of light. The instructions would therefore be something like this: "I am going to move the line. I want to adjust it so that it runs right through the center of the spot of light." The examiner then slowly turns the knob controlling the Risley prism in one direction or the other, meanwhile asking, "Is the line moving toward the light or away from it?" If the examinee replies that the line is moving away from the light, the examiner immediately begins turning the Risley prism control knob in the opposite direction, meanwhile asking, "Now is the line going toward the light?" When the examinee indicates that the line is moving toward the light, the examiner continues to turn slowly, saying,

"Now when the line runs through the exact center of the light, tell me to stop." When the examinee states that the line is running through the center of the light, the Maddox rod is rotated out of position in order that the calibrated scale on the Risley prism may be easily read. The scale reading is recorded.

(2) The examinee may often state in one breath that the line is running through the light and in the next breath state that this is no longer true. The examiner should reassure the examinee by indicating that it often happens and continue adjusting the prism until the line stops moving and an accurate reading can be made.

(6) *The Maddox Rod Test at 20 Feet (7 m).*—

(a) *Lateral Heterophoria.*—

(1) The examiner should always begin the test with the Risley prism set "off" of zero in one direction or the other, preferably on the "X" side (exophoria) so that some adjustment will have to be made.

(2) When the reading is completed, if lateral heterophoria was being measured, then if the prism marker is on the side of the line toward the examinee's nose (in the "X" area), exophoria is present; if on the side toward the examinee's temple (in the "S" area), esophoria is present.

(3) If any doubt exists in the mind of the examiner about the results of the test, the examinee should be referred to the medical officer in charge. The Maddox rod and rotary prism before the examinee's right eye should be rotated out of position and the rod and prism on the other side of the phorometer rotated into position before the left eye. The procedure described previously should then be repeated. If there is a great difference between the readings with the Maddox rod before the right eye and before the left eye, both should be repeated again. If there is only a small difference, i.e., 2 or 3 prism diopters, the larger of the two should be recorded as the lateral heterophoria (esophoria or exophoria as the situation indicates) for the examinee. A consistently large difference between the readings for the right and left eye indicates a partial paralysis of one of the extraocular muscles and calls for a repeated examination of the extraocular movements and a red lens test with charting of diplopia fields.

(b) *Vertical Heterophoria.*—

(1) When the lateral heterophoria has been tested, the next step is the measurement of vertical heterophoria. With the Maddox rod before the right eye, the rod should be adjusted so that the axes of its component glass rods are in the vertical. The eye behind the rod now will see the spot of light as a horizontal line. The Risley prism is turned down and out of position and the Steven's phorometer is turned up into its vertical position. Set the index of the Steven's phorometer at 2.0 LH (Left

Hyperphoria). The examinee is told that a horizontal line should be seen below the spot of light. The examiner grasps the controlling lever of the Steven's phorometer and moves the lever up slowly until the examinee states that the line bisects the spot of light. If the examinee reports that another spot of light is also seen, the examinee is told to ignore the *faint* spot and to watch the line until it bisects the bright spot. When this is done the examiner reads the scale in tenths of prism diopters of hyperphoria. As indicated on the Steven's phorometer, if the index is set below the zero position, the measurement is of left hyperphoria (LH), and if it is set above the zero position, the measurement is of right hyperphoria (RH). When testing the left eye, the relative positions of the line and spot of light are reversed. That is, with the index set at 2.0 LH (Left Hyperphoria) the line will appear to the examinee to be above the spot of light.

(2) *Only Hyperphoria Is Recorded.*—It has been previously stated that the eyes may deviate upward (hyperphoria) or downward (hypophoria). In most instances, when one eye turns up, its fellow eye tends to turn down. For simplification, only *hyperphoria* is recorded. Thus, if the right eye tends to turn upward, it is right hyperphoria. If the right eye tends to turn downward, the left eye would tend to turn upward in the majority of examinations and so left hyperphoria would be recorded. The proper finding, whether the Maddox rod is before the right or left eye, is always indicated on the Steven's phorometer by the letters RH or LH for right or left hyperphoria respectively.

(3) *Questionable Findings.*—If there is any doubt about the measurement in the mind of the examiner, the left eye should be tested in a similar fashion. This is done by placing the Maddox rod before the left eye instead of the right eye and by using the Steven's phorometer as described above. The only apparent change is the reversal of the relative positions of the line and the spot of light at the beginning of the test. A difference of more than 0.5 prism diopters between the right and left eye measurements should be cause for a recheck of the hyperphoria measurements for each eye. In such instances, it would be well to begin the test with the index set at 2.0 RH (Right Hyperphoria), the examiner moving the line in the opposite direction as described above until the line bisects the spot of light. The averages for the settings "from below" and "from above" when the Maddox rod is before the right and the left eyes should be compared. If the difference is greater than 1.0 prism diopter there is, in all probability, a slight paralysis of one or more of the extraocular muscles and a red lens test with the charting of the diplopia fields is indicated.

(4) *Examinations With More Than 2.0 Prism Diopters of Hyperphoria.*—Occasionally an examinee may have more than this amount of hyperphoria. This will be indicated at the beginning of the test by the examinee reporting that

the line appears above the spot of light instead of below when the index of the Steven's phorometer is set at 2.0 LH. Remove the Steven's phorometer and place the Risley prism in position with its handle in the horizontal and toward the examinee's temple. The line is then adjusted so that it runs through or bisects the spot of light. When this is done, set the index of the Risley to the nearest whole division toward zero and bring the Steven's phorometer into position. Now adjust the lever of this phorometer until the line bisects the spot of light. The sum of the readings on the Risley and the Steven's phorometer gives the total hyperphoria, and the position of the index of the Steven's phorometer indicates whether it is right or left hyperphoria that has been measured.

(7) *The Maddox Rod Test at 13 Inches (33.02 cm).*—

(a) When the test has been completed at the 20-foot (7 m) testing distance, the muscle light is turned off. The test should then be performed at 13 inches (33.02 cm), using an ophthalmoscope with its head removed as the muscle light. The light should be held exactly in the midline and 6 inches (15.24 cm) below the level of the examinee's eyes; thus the eyes are in the reading position. It may be necessary to lower the phorometer slightly in order to keep the eyes accurately centered. The light should be held at a distance of exactly 13 inches (33.02 cm) from the phorometer. A string tied to the center bar of the phorometer and looped at 13 inches (33.02 cm) will serve nicely. If the ophthalmoscope neck is slipped into the loop and the cord drawn taut, the light will be exactly 13 inches (33.02 cm) from the phorometer each time the test is performed.

(b) The technique of testing lateral and vertical heterophoria at 13 inches (33.02 cm) is exactly the same as that used at 20 feet (7 m). Occasionally the examinee may complain that more than one line at the 13 inch (33.02 cm) distance is seen. If the source of this annoying reflex cannot be found, the examinee should be instructed to pay attention only to the brightest line while it is adjusted so that it runs through or bisects the spot of light.

(d) *Testing With the Monocular, Portable Phorometer.*—The principle of measuring heterophoria with a Maddox rod and prisms may be applied in several different ways. Because the equipment available for the test varies from one station to the next, two additional testing methods will be described. At some installations there may not be a binocular phorometer available; instead, there may be only the monocular, portable type. This consists of a stick which has an eyepiece mounted at one end in a fixed position. Rotating on an axle attached to the eyepiece are a Risley rotary prism and a white Maddox rod. The instrument is held in position before the right eye by the examinee and the test is carried out exactly as has been previously described. It is the responsibility of the examiner to make certain that the instrument is held in the proper

position at all times during the test. If the right eye is being tested, the examinee should hold the instrument, with its handle vertical before the right eye with the left hand. The examiner adjusts the prism as before.

(e) *Testing With a Trial Frame and Loose Prisms.*—If no phorometer is available, a trial frame should be carefully adjusted on the examinee's eyes. A white Maddox rod from the trial case is placed in the cell before the right eye; its component rods should be placed with their axes horizontal if lateral heterophoria is to be tested first. Once the examinee has located both the line and the light, the examiner should select a weak prism and hold it before the Maddox rod with its base either in or out. Care must be taken to keep the base of the prism exactly vertical if lateral heterophoria is being tested or exactly horizontal if vertical heterophoria is being tested. Several prisms will probably need to be tried (both base in and base out) before one is found which causes the line to run through or bisect the spot of light. The rest of the procedure should be carried out exactly as has been described previously.

(f) *Checking the Maddox Rod.*—Two defects may occasionally be found in a Maddox rod:

(1) The line of light may be indistinct rather than sharp.

(2) There may be a prism effect which acts to deflect the line of light from its true position. A Maddox rod which is found to have either of these defects should be discarded. If the line of light formed by the rod is sharp and clear, any prism can be readily detected by holding the rod before one eye so that a horizontal line of light is seen while the other eye sees a spot of light. The position of the line in relation to the light is observed. The rod is then rotated through a full 180° and the line and light relationship observed again. If no prism is present, the relationship should be identical in the two observation positions described.

(g) *Checking Prisms.*—

(1) If a phorometer with a Risley rotary prism attached is not available for heterophoria testing, it will be necessary to use loose prisms. These may be available either in a trial case or in a special box (prism set). The strength of each prism should be etched upon the prism itself in units of prism diopters, this prismatic unit being one used throughout the Armed Forces. Unfortunately, not all prisms are marked in these units, some are not marked at all, and still others are marked incorrectly. It therefore becomes necessary to check the strength of each prism before it is used in the measurement of heterophoria. This can be very easily and very simply done.

(2) A diagram (see drawing) is made on a white sheet of paper 8½ X 11 inches (21.59 x 27.94 cm) in size. A heavy black line is drawn about 1 inch (2.54 cm) from and parallel to one edge. A second,

lighter line is drawn perpendicular to the heavy line in such a way that it roughly bisects it. Using a meter stick, units of 1 cm are laid off on the second line. These units should be numbered consecutively, the mark closest to the heavy line being numbered "1". This chart or diagram should then be tacked in place on the wall in such a manner that the heavy black line is vertical while the line with the centimeter markings runs to the left of the heavy line. A series of arrowheads added to the heavy line below the point of the intersection will facilitate the checking.

(3) The prism to be checked is held at a distance of *exactly 1 meter* from the diagram on the wall and in a plane parallel to the plane of the wall. The base of the prism should be held in the vertical, toward the right, and parallel to the heavy black line on the chart. The examiner should then place the eye at a distance of about 4 inches (10.16 cm) from the prism in such a position that the heavy black line can be viewed through it. As shown in the drawing, the top edge of the prism should be held so that it is just below but almost coincides with the lighter marked line on the diagram. The position of the heavy black line above the intersection of the two lines should be such that it strikes the prism's upper edge at about its center. If the left eye is now closed and one looks through the prism, held in the position described, the heavy black line will appear to break at the prism edge and continue its downward course in a position to the left of its original one. The centimeter marking to which the arrowheads on the displaced portion of the heavy line point is a measurement of the strength of the prism in diopters. If the arrowheads point to a spot between two markings, the appropriate fraction can be easily estimated. If the test is carried out as described and the displaced portion of the heavy line intersects the marked line at 3, for example, then the prism being tested has a strength of 3 diopters. If the displaced portion intersects the marked line at 5, it is a 5 diopter prism, etc.

(4) Two things must always be known about a prism:

(a) Its strength in prism diopters.

(b) The position of its base.

In testing heterophoria, the prism base is placed in the following positions:

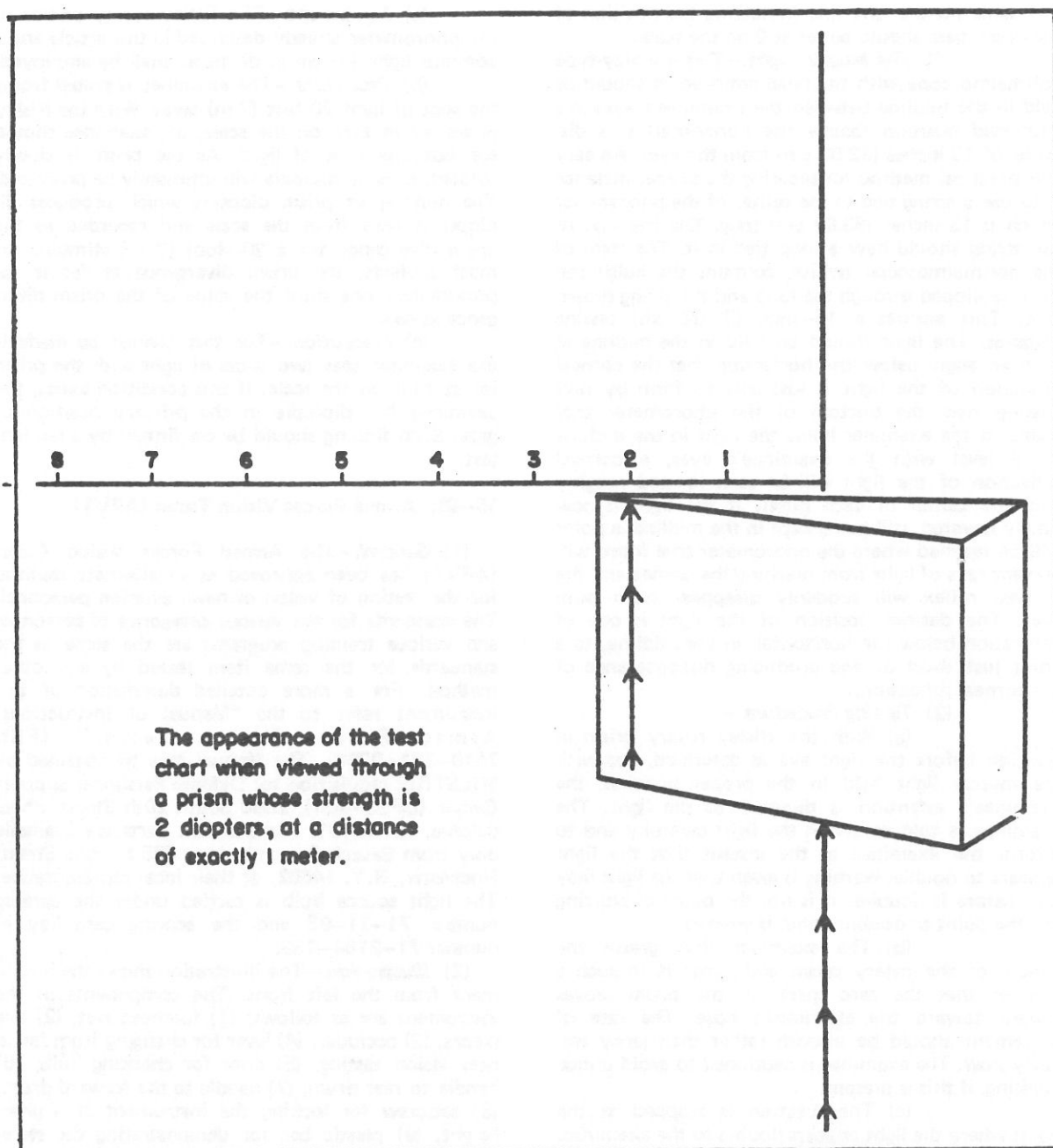
For exophoria, prism base in (toward the nose).

For esophoria, prism base out (toward the temple).

For hyperphoria, prism base down (toward the cheek).

For hypophoria, prism base up (toward the eyebrow).

(2) *TESTING PRISM DIVERGENCE AT NEAR (13 INCHES (33.02 CM)).*—A test of prism divergence is essentially a test of fusion. Tests for heterophoria depend upon breaking up fusion as much as possible. If prism divergence is tested before



heterophoria is measured, the heterophoria measurements will be affected. It is therefore important always to test heterophoria *before* testing prism divergence.

(a) *Equipment.*—The equipment for testing prism divergence is the same as that described for testing heterophoria in a previous section of this article.

(b) *Procedure for Testing Prism Divergence at Near.*—The procedure of seating the examinee and adjusting the phorometer is also identical with that for testing heterophoria, previously described. The only difference is that the Maddox rod is not used. The Risley rotary prism is rotated into position before the right eye. The handle of the rotary prism should be rotated to the vertical (90°). By means of

this same handle, the line indicating the position of the prism base should be set at 0 on the scale.

(1) *The Muscle Light.*—This is a May-type ophthalmoscope with the head removed. It should be held in the midline between the examinee's eyes in a depressed position (below the horizontal) at a distance of 13 inches (33.02 cm) from the eyes. An easy and practical method for securing the proper distance is to use a string tied to the center of the phorometer which is 13 inches (33.02 cm) long. The free end of the string should have a loop tied in it. The stem of the ophthalmoscope (which contains the bulb) can then be slipped through the loop and the string drawn taut. This ensures a 13-inch (33.02 cm) testing distance. The light should be held in the midline at such an angle below the horizontal that the corneal reflection of the light is just able to form by rays passing over the bottom of the phorometer trial frame. If the examiner holds the light in the midline on a level with the examinee's eyes, a corneal reflection of the light will be seen located roughly over the center of each pupil. If the light is now slowly lowered, still being kept in the midline, a point will be reached where the phorometer trial frame will prevent rays of light from reaching the cornea and the corneal reflex will suddenly disappear from both eyes. The desired position of the light is one of depression below the horizontal, in the midline, to a point just short of one producing disappearance of the corneal reflection.

(2) *Testing Procedure.*—

(a) With the Risley rotary prism in position before the right eye as described, and with the muscle light held in the proper position, the examinee's attention is directed to the light. The examinee is told to watch the light carefully and to inform the examiner at the instant that the light appears to double. Warning is given that the light may blur before it doubles. It is not the point of blurring but the point of doubling that is wanted.

(b) The examiner then grasps the handle of the rotary prism and turns it in such a manner that the zero mark on the prism moves inward toward the examinee's nose. The rate of movement should be smooth rather than jerky and fairly slow. The examinee is cautioned to avoid undue blinking, if this is present.

(c) The rotation is stopped at the point where the light appears double to the examinee. A reading is then taken from the calibrated scale on the rotary prism and is recorded as prism divergence at 13 inches (33.02 cm). The average normal figure in this test is around 19 prism diopters. The examinee must have a reading of 12 prism diopters or better to qualify.

(3) *TESTING PRISM DIVERGENCE AT FAR (20 FEET (7 m)).*—The same precautions noted under testing for prism divergence at 13 inches (33.02 cm) earlier in this section shall be observed.

(a) *Equipment.*—The Risley rotary prisms of the phorometer already described in this article and a stimulus light 1.0 cm in diameter shall be employed.

(b) *Procedure.*—The examinee is seated facing the spot of light 20 feet (7 m) away. With the Risley prism set at zero on the scale, the examinee should see but one spot of light. As the prism is slowly rotated, base in, diplopia will ultimately be produced. The number of prism diopters which produces diplopia is read from the scale and recorded as the prism divergence for a 20-foot (7 m) stimulus. In most subjects, the prism divergence at far is approximately one third the value of the prism divergence at near.

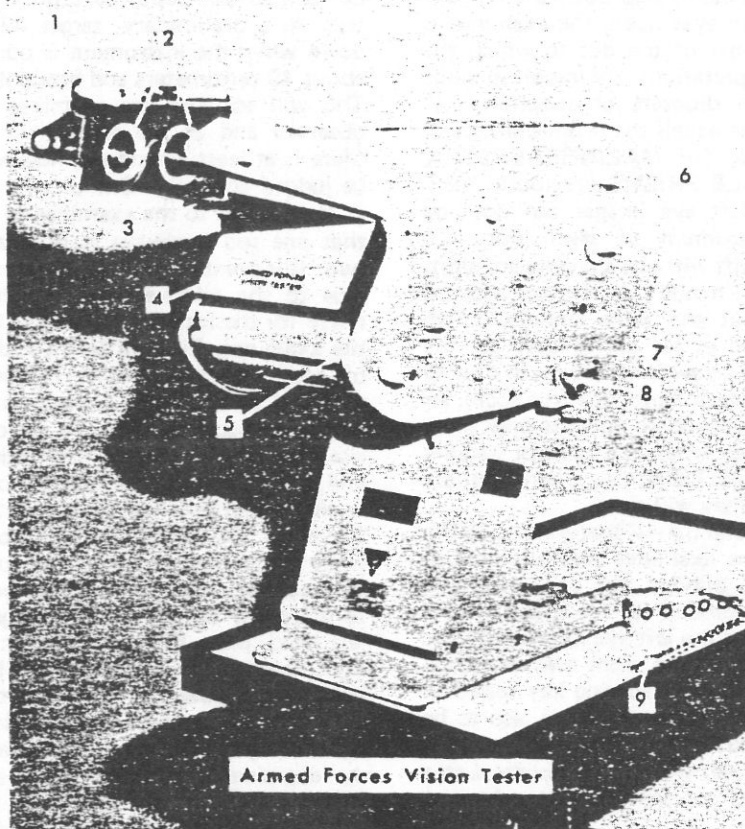
(c) *Precaution.*—The test cannot be made if the examinee sees two spots of light with the prism set at zero on the scale. If this condition exists, the examinee has diplopia in the primary position of gaze. Such finding should be confirmed by a red lens test.

15-95. Armed Forces Vision Tester (AFVT)

(1) *General.*—The Armed Forces Vision Tester (AFVT) has been approved as an alternate method for the testing of vision of naval aviation personnel. The standards for the various categories of personnel and various training programs are the same as the standards for the same item tested by any other method. For a more detailed description of this instrument refer to the "Manual of Instructions: Armed Forces Vision Tester" (FSN 7610-721-9390). The Manual may be obtained by MILSTRIP requisition to: Defense Personnel Support Center (DPSC-ASI), 2800 South 20th Street, Philadelphia, Pa. 19101. Replacement parts are available only from Bausch & Lomb, Inc., 635 St. Paul Street, Rochester, N.Y. 14602, or their local representative. The light source bulb is carried under the catalog number 71-71-93 and the scoring card key as number 71-2164-139.

(2) *Illustration.*—The illustration shows the instrument from the left front. The components of the instrument are as follows: (1) forehead rest, (2) eye pieces, (3) occluder, (4) lever for changing from far to near vision testing, (5) door for checking bulb, (6) handle to rear drum, (7) handle to the forward drum, (8) setscrew for locking the instrument at a given height, (9) plastic bar for demonstrating the stereopsis test.

(3) *Description.*—The AFVT consists of two rotating drums holding illuminated slides for the testing of various facets of vision. The examinee observes the distance slides looking slightly downward with the instrument set as shown in the illustration and observes the near slides looking downward at a greater angle. The handles on the side of the instrument rotate the drums to change the slides. Beneath the eye pieces there is a lever which operates



an occluder so that each eye can be tested separately; or, as in the examination of the slides for muscle balance and stereopsis, the two eyes can be tested together. A scoring key is provided with the instrument. The following slides are available:

(a) *Rear Drum (Distance Testing).*—

(1) *Slide 1—Vertical Phorias.*—The right eye sees a set of numbered steps, the left sees a dotted line. With both eyes open the examinee is asked which step the dotted line intersects. Interpretation: Step 1, 2 prism diopters of left hyperphoria; step 2, 1.5 left hyperphoria; step 3, 1.0 left hyperphoria; step 4, 0.5 left hyperphoria; step 5, orthophoria; step 6, 0.5 prism diopters of right hyperphoria; step 7, 1.0 right hyperphoria; step 8, 1.5 right hyperphoria; step 9, 2.0 right hyperphoria. **DETECTION OF MALINGERERS:** It would be possible for the examinee to feign a normal phoria if it is known that a score of 5, for example, is normal. To avoid this, a pair of **VARIABLE PRISMS** is provided, by means of which the examiner can raise either the right or the left eye image. The prisms are mounted within the viewing box. The extent of prismatic

deviation is governed by the position of each of two control handles. These handles are not visible in the illustration, but are clearly visible to the examiner when looking down on the top of the instrument. The correct score—and the only score recorded—is that obtained when *both* control handles of the **VARIABLE PRISMS** are pushed inward as far as they will go. This is known as the **SCORING POSITION**. Moving the left handle outward from this position moves the left eye image downward and outward. Similarly, moving the right handle outward moves the right-eye image downward and outward. The maximum amount of downward shift provided by each control corresponds to four steps. Moving the right handle outward to its extreme position therefore will change the apparent location of the dotted line from step 1 to step 5, for example, from 6 to above 9, etc. Moving the left control handle outward to its extreme position similarly will change the apparent location of the dotted line from step 5 to step 1, or from step 8 to step 4, etc. The examiner varies the location of the right *or* left control handle, each time asking the examinee to report the location of the dotted line.

One of these answers only, i.e., the one obtained when both handles are in the SCORING POSITION, gives the examinee's score on the test.

(2) *Slide 2—Horizontal Phorias.*—The right eye sees a row of numbered dots, the left eye sees an arrow. With both eyes open, the examinee is asked what is the number of the dot to which the arrow is pointing. Interpretation: The reported value minus 11 equals prism diopters of exophoria; 11 minus the reported value equals the prism diopters of esophoria. DETECTION OF MALINGERERS: By means of the VARIABLE PRISMS previously mentioned, the right and left eye images can both be shifted outward a maximum of seven dots. To produce this outward shift without a downward shift, in this test both control handles are moved outward simultaneously by about the same amount. When both handles are shifted as far out as they go, the apparent position of the arrow is moved seven dots to the left, giving a score seven below the true score. As in previous test, the correct score and the only score recorded is that obtained when the control handles are in the SCORING POSITION; i.e., when both are pushed inward as far as they will go.

(3) *Slides 3 and 3A—Visual Acuity.*—With both eyes uncovered the examinee sees a jumble of letters. With either eye blinded, the uncovered eye cannot see the letters intended for the opposite eye. An examinee cannot read the left eye letters with the right eye and then repeat them from memory when the left eye is being tested. A scoring key sealed in plastic comes with the instrument and is also to be found in the AFVT Manual of Instructions.

(4) *Slides 4 and 4A—Visual Acuity, Large Letters.*—Separate charts for the left and right eye. See scoring key.

(5) *Slides 5 and 5A—Stereopsis.*—Six groups of three horizontal lines, five circles to a line. The groups are numbered A to F. In each horizontal row of circles, one circle stands out closer to the examinee. The degree of difficulty increases from A to F. The examinee calls the circle which stands out. Passing score: There must be no misses in groups A through D. Caution: The examiner must ensure that neither eye is inadvertently left occluded when this test is being given. Both eyes must be able to see the circles in order for any stereopsis to occur.

(b) *Front Drum (Near Testing).*—

(1) *Slide 6—Vertical Phorias.*—Same as slide 1, only this is a near test.

(2) *Slide 7—Horizontal Phorias.*—Same as slide 2, only here the interpretation is: The reported value minus 13 equals prism diopters of exophoria; 13 minus the reported value equals prism diopters of esophoria.

(3) *Slide 8—Near Visual Acuity.*—This is given in Snellen notations.

(4) *Slide 9—Near Visual Acuity, Large Letters.*

15-96. Depth Perception

(1) When the Armed Forces Vision Tester (AFVT) is unavailable, the Verhoeff stereopter may be used to test depth perception. This is a binocular test. As a preliminary, target #2 (the second target down when the instrument is upright) is presented at about 40 centimeters and brought nearer if necessary. This will acquaint the examinee with what is to be observed and at the same time determine whether there is at least a distance, however short, which can be judged correctly. One or two positions are shown at close range to the examinee to clearly demonstrate that one rod is always at difference from the other two. It is pointed out that the size of the rods is not a clue to the relative distance. The examinee is now ready for the test. The apparatus is held 1 meter from the examinee. Eight different rod relations are possible and all eight are shown. The device should be kept centered as a frontal plane normal to the subject's binocular visual midline. To avoid helpful extraneous cues it is highly important to hold the device steady, and particularly not to rotate it on its vertical axis. It is also important not to permit the subject to move the head. The target window should not be exposed while the device is being placed in position or the sets are changed. A convenient method of manipulation is to grasp the device over the target window with the left hand, place the desired set into position with the right hand, then grasp the device below with the right hand and expose the target window by moving the left hand up or down. Thus while the target window is exposed, the device is supported by both hands of the examiner. The instructions to the subjects are: "Report the nearest strip and the farthest strip, unless they all appear to be at the same distance, referring to the strips as 'left,' 'middle,' and 'right'." Only the report concerning the one strip out of plane (farther or nearer than the other two which are in the same plane) is to be considered.

15-97. Color Vision Testing

(1) *Farnsworth Lantern Test (FALANT).*—The FALANT was developed to pass persons with normal color vision and color defective individuals who have mild color defects. Color vision shall be determined by the FALANT in all instances where this test is available. The results obtained by the FALANT shall be considered final in the resolution of instances of questionable color vision.

(2) *General.*—Instructions for administering, scoring, and operating the Farnsworth Lantern are attached to a metal plate on the lantern. These instructions are also described in more detail in this article. It is essential that the test be given at the appropriate distance, that the examinee be given written instructions, and that all nine combinations of lights be given in a random (mixed) order.

Techniques for easy implementation of these conditions are listed below.

(3) *Administration and Scoring.*—

(a) The instructions for the examinee are: "The lights you will see in this lantern are either red, green, or white. They look like signal lights at a distance. Two lights are presented at a time in any combination. Call out the colors as soon as you see them, naming first the color at the top and then the color at the bottom. Remember, the three colors are *red, green, and white*, and remember also to call out the *top color first*."

(b) Turn the knob at the top of the lantern to change the lights; depress the button in the center of knob to expose the lights. Maintain regular timing of about 2 seconds per exposure.

(c) Start the test by exposing a red/green or green/red combination (#1 or #5). Using a random (mixed) selection, continue until each of the 9 combinations has been exposed. Random selection means that, after exposure of #1 or #5, the examiner gently rotates the undepressed knob for a few numbers to the right or to the left to obtain the next number for presentation. Avoid presenting the numbers in a regular sequence. This process is continued until all 9 lights have been exposed. If a previously presented number is selected again, after rotating the knob, then rotate the knob until a new number is selected.

(d) If no errors are made on the first run of 9 pairs of lights, the examinee has passed the test.

(e) If any errors are made on the first run, continue testing until two more complete runs have been given. Do not give a break or make any comments between runs.

(f) Total the errors on the *last two* runs and divide the results by two to obtain the average error score. (See subart. (5)(c) below for passing criteria.)

(g) A single error is made if either one or both lights of a pair are misnamed. If an examinee changes a response before the next pair of lights is presented, record the second response only.

(h) If an examinee ordinarily wears glasses for distance, the examinee should wear them during the test.

(i) If an examinee says "yellow," "pink," etc., remind the examinee that, "There are only three colors—red, green, and white."

(j) If an examinee takes a long time to respond, tell the examinee that, "As soon as you see the lights, call them."

(4) *Operation of the Lantern.*—

(a) Give the test in a *normally lighted* room; screen from glare; exclude sunlight. The examinee should not face the source of room illumination.

(b) Only one individual should be tested at a time. (Other examinees shall not be allowed to watch.)

(c) Station the examinee 8 feet (244 cm) from the Lantern.

(d) The examinee may stand or sit; tilt the Lantern by adjusting the screw at the back of the Lantern so that the opening in the face of the Lantern is directed at the eyes of the examinee.

(e) Operate on 110–120 volts, AC or DC. Use only an Airport Marker Lamp (clear, 40 watt, 115 volts, T8, Code40T8/3) as a replacement bulb. These bulbs may be procured from the Federal Supply Catalog. Keep a spare bulb in the receptacle provided in the base of the lantern.

(5) *Improved Techniques for Achieving Appropriate Testing Conditions.*—

(a) *Instruction Card.*—The following set of instructions to the examinee (as it appears on the metal plate attached to the lantern) shall be typed in large print, pasted on a stiff card, laminated, and handed to each examinee to read immediately before being tested:

THE LIGHTS YOU WILL SEE IN THIS LANTERN ARE EITHER RED, GREEN, OR WHITE. THEY LOOK LIKE SIGNAL LIGHTS AT A DISTANCE. TWO LIGHTS ARE PRESENTED AT A TIME IN ANY COMBINATION. CALL OUT THE COLORS AS SOON AS YOU SEE THEM. NAME FIRST THE COLOR AT THE TOP AND THEN THE COLOR AT THE BOTTOM. REMEMBER, THE THREE COLORS ARE *RED, GREEN, AND WHITE*, AND REMEMBER, ALSO TO CALL OUT THE *TOP COLOR FIRST*.

Note: IF YOU USE GLASSES FOR DISTANCE, PLEASE WEAR THEM DURING THIS TEST.

In a corner of this FALANT instruction card, the examiner should punch a hole and attach an 8-foot (244 cm) cord to it. The other end of the cord should be attached to the front of the lantern. After arriving for the FALANT test, the examinee should be handed the instruction card and asked to walk straight out from the lantern until the cord is taut and at eye level. When this is done, the examinee should then be told to read the instructions aloud.

(b) *Scoring Template.*—A scoring template should be used to record errors and for monitoring the random light selection. Random selection means that, after exposure of #1 or #5, the examiner gently rotates the undepressed knob a few numbers to the right or to the left to obtain the next number for presentation. Avoid presenting the numbers in a regular sequence. This process is continued until all 9 lights have been exposed. If a previously presented number is selected again after rotating the knob, then rotate the knob until a new number is selected. The following scoring template and instructions should be

typed, pasted on a stiff card, laminated, and used by the examiner each time the FALANT is administered:

(Front)

Farnsworth lantern scoring template

Light number	#1	#2	#3	#4	#5	#6	#7	#8	#9
Color pair (G—green; R—red; W—white)	G	W	G	G	R	W	W	R	R
	R	G	W	G	G	R	W	W	R

(Back) (Instructions for use)

Place the template at the top of a sheet of paper. Administer the test according to instructions. Record right or wrong responses below the appropriate column on the template using "+" or "-" signs; continue in random order until all 9 combinations have been exposed. Slide the template down to an unused portion of the paper for the next run (same or different examinee).

Note: Do not spin the knob with force or it will break.

(c) *Passing Criteria.*—If the examinee has an average error score of one or less, the test has been passed. If the average error score is *more than one*, the test has been failed. If the examinee has an average error score of 1.5, the score is "borderline" and the test should be repeated after a 5-minute break. During the retest, the examinee should again read the FALANT instruction card and the examiner should give three more complete runs of 9 lights per run. Average the errors of the last two runs and record this score as the FALANT result. Note: Do not repeat tests for examinees with average error score over 1.5; this practice invalidates the test results.

(6) *Pseudoisochromatic Plate Test.*—

(a) Color vision shall be determined by the pseudoisochromatic plate test *only* if a Farnsworth Lantern is not available. Personnel so tested must be administered the FALANT at the first activity to which they report that has a Farnsworth Lantern.

(b) When the pseudoisochromatic plates are used, a color vision lamp with a daylight filter (found in the GSA Supply Catalog under "Light, Color Perception Testing") shall be used for illumination. Room lights shall be turned off and window blinds or shades shall be drawn so that the only illumination is from the color vision lamp with a daylight filter. The examinee shall *not* be allowed to *touch the plates*. The plates shall be shown at a distance of 30 inches (76.2cm) from the examinee, and only 2 seconds shall be allowed to identify each plate. If the examinee hesitates, the examinee should be asked again to "read the numbers." If the examinee fails to respond, the examiner must turn to the next plate without comment. Only one examinee shall be in the test room when examined on the pseudoisochromatic plates. The plates shall be administered in random

(mixed) order and the entire selection of plates must be shown.

(c) Examinees shall be qualified as follows:

(1) *18-plate test:* When the examinee reads correctly at least 14 of the 17 test plates (demonstration plate excluded).

(2) *15-plate test:* When the examinee reads correctly at least 10 of the 14 test plates (demonstration plate excluded).

(7) *Recording Results.*—The results of color vision testing (either FALANT or pseudoisochromatic plates) shall be recorded in block 64 of Standard Form 88. For the FALANT, enter "Passed FALANT" or "Failed FALANT" and note the number of errors for each of the runs that were given (e.g., "Passed FALANT: 1st run—1, 2nd run—0, 3rd run—1" or "Failed FALANT: 1st run—3, 2nd run—2, 3rd run—3"). For the pseudoisochromatic plates, enter "Passed PIP" or "Failed PIP" and note the number of correct responses (e.g., 17 of 17, 10 of 17, 14 of 14, 5 of 14, etc.).

15-98. Examination of Heart and Blood Vessels

(1) (a) *General.*—The applicant should stand before the examiner with direct light falling upon the chest. The examinee should stand at ease, with the arms relaxed and hanging by the sides. The examiner should not permit the applicant to move the body from side to side or twist it in an endeavor to assist in the examination, as these maneuvers may distort landmarks and increase muscular resistance of the chest wall. The heart should be examined by the following method: inspection, palpation, percussion, auscultation, and when considered necessary, by mensuration. Blood-pressure readings and palpation of the pulse are required for candidates for commission and for applicants for enlistment. Electrocardiograms and X-rays for cardiac mensuration should be made in doubtful situations.

(b) *Inspection.*—Begin from above and go downward, with special reference to the following: condition and color of skin and mucous membranes; eyes for arcus senilis; visible pulsations of the vessels of the neck; enlargement of the thyroid gland; the shape of the chest, for any malformation which might change the normal relations of the heart; pulsations in the suprasternal notch, and in the second interspaces to right and left of the sternum; character of the precordial impulse, and the location and character of the maximum impulse, epigastric pulsations or pulsations in the hepatic region, and any pulsations or retractions in the back.

(c) *Palpation.*—Palpate first for the detection of thrills over the carotids, thyroid gland, suprasternal notch, apex of heart, and at the base. Use palms of hands in palpating and use light pressure, as hard pressure may obliterate a thrill. To locate the maximum cardiac impulse, have the applicant stoop and throw the shoulders slightly forward, thus

bringing the heart into the closest possible relation with the chest wall. Palpate both radial arteries at the same time for equality in rate and volume. Run the finger along the artery to note any changes in its walls. Place the palm of one hand over the heart and fingers of the other over the radial artery to see if all ventricular contractions are transmitted. Palpate to determine the degree of tension or compressibility of the pulse. In an estimate of pulse rate, the excitement of undergoing a physical examination must be considered and a rate of 90 may be considered normal, provided the heart responds normally to the exercise test. A rate of 50 or below should excite suspicion of heart block and be made the subject of further investigation. Rates of 100 or over should be investigated with a view to the exclusion of heart lesions and hyperthyroidism.

(d) *Percussion*.—Light mediate percussion should be used. The right and left cardiac borders, as well as the diameter of the transverse arch, may be determined by percussion. In doubtful instances in which it is important to determine the actual cardiac boundaries, teleroentgenography should be employed.

(e) *Mensuration*.—Draw a line down the mid-sternum, from the suprasternal notch to the tip of the ensiform cartilage. Measurements are made at right angles to this line, at the second interspace (aortic dullness), at the fourth interspace to the right for any increase in the right border, and at the fifth interspace to the left for any increase in the left border. The following measurements may be considered normal for the average young adult:

(1) From midsternal line to right border at fourth interspace, 3cm.

(2) From midsternal line to left border along fifth interspace, 8.5 cm.

(3) The normal aortic dullness at the second interspace to the right and left of the midsternal line is 5.5 cm.

(f) *Auscultation*.—In auscultating the heart, the examiner should bear in mind the four points where the normal sounds of the heart are heard with maximum intensity:

(1) Aortic area, second interspace to right of sternum. Here the second sound is distinct.

(2) Tricuspid area, at the junction of the fifth right rib with the sternum. Here the first sound is distinct.

(3) Pulmonic area, second interspace to left of sternum. Here the second sound is most distinct.

(4) Mitral area, fifth interspace to left of sternum. Here the first sound is most clearly heard. No auscultatory examination is to be considered complete unless the subject is examined in the upright, recumbent, and left lateral recumbent positions and after exercise, and in the different phases of respiration. The examiner should ascertain whether the applicant has had any of the following diseases:

scarlet fever, diphtheria, chorea, rheumatic fever, tonsillitis, hemolytic streptococcal infection, syphilis, or tuberculosis.

(2) (a) *Examination After Exercise*.—Examiners shall use judgment and discretion in applying the exercise test to those who present evidence of incompetency of the heart. An exercise test is required in order to determine the efficiency of the heart muscle. The applicant should be required to hop 20 times on one foot not faster than one hop per second, clearing the floor about 1 inch (2.5cm) at each hop. Record sitting pulse rate and blood pressure before exercise. Immediately after exercise, record pulse rate, and 2 minutes after exercise record pulse rate and blood pressure. Immediately after the exercise, auscultation should be repeated with particular reference to the detection of murmurs previously inaudible. Note should be made of the degree of dyspnea and other symptoms of circulatory failure.

(b) *Consideration of Blood Pressure*.—In considering the blood pressure, the examiner should give due regard to the age of the applicant and to physiological causes, such as excitement, recent exercises, loss of sleep, and digestion. The condition of the arteries, the tenseness of the pulse, and the degree of accentuation of the aortic second sound must be taken into consideration, as well as the relation between the systolic and diastolic pressure. No applicant shall be rejected as a result of a single reading. When the blood pressure estimation at the first examination is regarded as abnormal, or in instances of doubt, the procedure shall be repeated twice daily (in the morning and in the afternoon) for a sufficient number of days to enable the examiner to arrive at a definite conclusion. For those individuals with elevated blood pressure an average of the readings taken, with the individual as free from stress as possible, should be reported rather than the results of a single high or low reading. However, a representative sample of the highest and lowest readings shall also be recorded.

(c) *Resting Blood Pressure*.—The resting blood pressure is to be taken with the examinee comfortably relaxed in a sitting position with legs uncrossed and the arm placed on a rest at the horizontal level of the heart. The systolic blood pressure reading is to be taken as the level at which the first clear tapping sound appears during slow decompression of the blood pressure cuff. As the blood pressure cuff is further decompressed the auscultatory sound becomes murmurlike, then it becomes clearer and louder, and finally it becomes muffled in character. The diastolic blood pressure reading is to be taken as the level at which this fourth phase (the muffled sound) abruptly drops in intensity or disappears.

(d) *Interpretation of Abnormal Signs and Symptoms*.—The following principles are laid down for the guidance of examiners in their interpretation of abnormal signs and symptoms. It should be

constantly borne in mind that the excitement of the examination may produce violent and rapid heart action, often associated with a transient systolic murmur. Such conditions may erroneously be attributed to the effects of exertion; they usually disappear promptly in the recumbent posture, but the examiner must endeavor to recognize the excitable individuals to take measures to eliminate psychic influences from the test so far as possible.

(e) *Hypertrophy and Dilatation*.—An apex beat located at or beyond the left nipple line, or below the sixth rib, suggests an enlargement sufficient to disqualify for military service. Its cause, either valvular disease or hypertension in the majority of instances, should be sought. Clear cut radiologic evidence of heart enlargement is cause for rejection. A horizontal position of the heart must be distinguished from left ventricular enlargement. Fluoroscopy and teleroentgenography are important adjuncts in the diagnosis of enlargement of the cardiac chambers, particularly the left auricle. The left oblique position may reveal early enlargement of the latter chamber. Enlargement, however, should not be made a primary diagnosis unless careful examination fails to reveal a cause.

(f) *Physiological Murmurs*.—Cardiac murmurs are the most certain physical signs by which valvular disease may be recognized and its location determined. The discovery of any murmurs demands diligent search for other evidence of heart disease. Murmurs may occur, however, in the absence of valvular lesions or other cardiac disease. Such physiological murmurs are not causes for rejection. The following characteristics of physiological murmurs will enable the medical examiner to differentiate them from organic murmurs:

- (1) They are always systolic in time.
- (2) They are usually heard over a small area, the most common places being over the pulmonic valve and the mitral valve.
- (3) They change with position of the body, disappearing in certain positions. They are loudest usually in the recumbent position and are sometimes heard only in that position.
- (4) They are transient in character, frequently disappearing after exercise.
- (5) They are usually short, rarely occupying all of a systole, and are soft and of a blowing quality.

(6) There is no evidence of heart disease or cardiac enlargement.

(7) The most frequent types of physiological murmurs are:

(a) Those heard over the second and third left interspaces during expiration, disappearing during forced inspiration. These are particularly common in men with flexible chests, who can produce extreme forced expiration. Under such circumstances, murmurs may be associated with a vibratory thrust.

(b) Cardio-respiratory murmurs occasioned by movements of the heart against air in a part of the lung overlapping the heart. They usually vary in different phases of respiration, and at times disappear completely when the breath is held.

(c) Prolongations of the apical first sound, which are often mistaken for murmurs.

15-99. Examination of Range of Motion

(1) The applicant shall be put through a series of movements similar to those described below, which will bring into action the various joints and muscles of the body. The purpose is best accomplished by requiring the applicant to follow the movements as made by the examiner or an assistant.

(a) Bring the elbows firmly to the sides of the body with the forearms extended to the front, palms of the hands uppermost; extend and flex each finger separately; bring the tips of the thumbs to the base of the little fingers; close the hands, with the thumbs covering the fingers; extend and flex the hands on the wrists; rotate the hands so that the fingernails will first be up and then down; move the hand from side to side. Extend the arms and forearms fully to the front and rotate them at the shoulders with the fists. Extend the arms at right angles with the body; place the thumbs on the points of the shoulders; raise and lower the arms, bringing them sharply to the sides at each motion. Let the arms hang loosely by the sides; swing the right arm in a circle rapidly from the shoulder, first to the front and then to the rear; swing the left arm in the same manner. Extend the arms fully to the front, keeping the palms of the hands together and the thumbs up; carry the arms quickly back as far as possible, keeping the thumbs up, and at the same time raise the body on the toes. (Question the candidate regarding any previous dislocations of the shoulder.) Extend the arms above the head, locking the thumbs, and bend over to touch the ground with the hands, keeping the knees straight. Perform two push-ups from the floor. (Question the candidate as to wrist injury for possible scaphoid fracture.)

(b) Extend one leg, lifting the heel from the floor, and move all the toes freely; move the foot up and down and from side to side, bending the ankle joint, the knee being kept rigid; bend the knee freely; kick forcibly backward and forward; throw the leg out to the side as far as possible, keeping the body squarely to the front; repeat all these movements with the other foot and leg; strike the breast first with one knee and then with the other; stand up on the toes of both feet; squat sharply several times; kneel upon both knees at the same time. (If the applicant comes down on one knee after the other there is reason to suspect infirmity, such as injury to menisci. Question the candidate as to previous injury.)

(c) Take the position "to fire kneeling"; stand erect, present the back to the examiner, and then hold up to view the sole of each foot; leap directly up, striking the buttocks with both heels at the same time, hop the length of the room on the ball of first one foot and then the other; make a standing jump as far as possible and repeat it several times; run the length of the room several times.

(2) While the exercises prescribed may cause some breathlessness and accelerated throbbing of the blood vessels, they should not cause manifest exhaustion or great distress in a healthy person. Lack of ability to perform any of these exercises indicates some defect or deformity that should be investigated further.

15-100. Orthopedic Examination of Major Joints

(1) *The Shoulder.*—With the examinee stripped to the waist, inspect both anteriorly and posteriorly for asymmetry or abnormal configuration or muscle atrophy. From the back, with the examinee standing, observe the scapulo-humeral rhythm as examinee elevates the arms from the sides directly overhead, carrying the arms up laterally. Any arrhythmia may indicate shoulder joint abnormality and is cause for particularly careful examination. Palpate the shoulders for tenderness and test range of motion in flexion, extension, abduction, and rotation. Compare each shoulder in this respect. Test muscle power of abductors, adductors, flexors and extensors of the shoulder, as well as power in internal and external rotation. Have the examinee attempt to lift a heavy weight with arm at the side to establish integrity of the acromioclavicular joint.

(2) *The Back.*—

(a) With the examinee standing stripped, note the general configuration of the back, the symmetry of the shoulders and hips and any abnormal curvature including scoliosis, abnormal dorsal kyphosis, or excessive lumbar lordosis. Palpate the spinous processes and the erector spinae muscle masses for tenderness. Determine absence of pelvic tilt by palpating iliac crests. Have examinee flex, extend spine and bend to each side, noting ease with which this is done and the presence or absence of pain on motion. Test rotary motion by gripping the pelvis on both sides and having the examinee twist to each side as far as is possible. Measure chest expansion. With the examinee sitting on the examining table, test patellar and ankle reflexes and fully extend the knee, noting complaints of pain. (This corresponds to a 90-degree straight leg raising test in supine position.) With the examinee supine, test dorsiflexor muscle power of the foot and toes, with particular attention to power of the extensor hallucis longus. Weakness may indicate nerve root pressure on S1. Flex hip fully on abdomen with knee flexed and determine presence or absence of pain on extremes of rotation of each hip with hip flexed to 90 degrees. Frequently, in lumbosacral sprains of chronic nature, pain is experienced on

these motions. Place the heel on the knee of the opposite extremity and let the flexed knee fall toward the table. Pain or limitation indicates either hip joint and/or lumbosacral abnormality. While lying prone, have the examinee extend back (arch the back) and test strength in extension by noting degree to which this is possible.

(b) If pain is experienced on back motions in association with these maneuvers or if there is asymmetry or abnormal configuration, back X-rays, including the pelvis, should be obtained. These should include an anteroposterior, lateral, and oblique views.

(3) *The Knee.*—

(a) With trousers, shoes, and socks removed, observe general muscular development of legs, particularly the thigh musculature. Have examinee squat, sitting on heels, and observe hesitancy, weakness, and presence or absence of pain or crepitus. With examinee sitting, test for ability to extend the knee fully and test power in extension by making pressure on lower leg with knee extended. Compare equality of power in each leg. With knee flexed, test for hamstring power by attempting to pull leg into extension; compare equality of strength in each leg. Palpate entire knee for tenderness.

(b) With the examinee still sitting on the table's edge, sit and grasp the examinee's heel between the knees; then test for cruciate ligament stability by first pulling the tibia anteriorly on the femur and by then pushing the tibia posteriorly on the femur (the so-called "Drawer sign"). With the patient supine, mark on each leg a distance 1" (2.54 cm) above the patella and 6" (15.24 cm) above the patella, making sure this is done with muscles relaxed. Measure circumferences at these levels and note presence or absence of atrophy. Test the medial and lateral collateral ligaments by placing varus and valgus strain on the extended knee. Manipulate the knee through a complete range of flexion and extension, noting any difference between the sides and any abnormal restriction.

(c) In the presence of any history of "locking," recurrent effusion or instability, as well as when atrophy measured is more than 3/8" (.95 cm) or when limitation of motion or ligamentous instability is detected, suitable X-rays should be obtained which should include an anteroposterior, lateral, and intercondylar view.

(4) *The Elbow.*—With the examinee stripped to the waist and holding the upper arms against the body with the forearms extended and fully supinated, observe for presence of a normal carrying angle. Have the examinee flex the elbows to a right angle and keeping the elbows against the body note ability to fully supinate and pronate the forearms. Test medial and lateral stability by placing varus and valgus strain on the joint with the elbow extended. Test the power of the flexor, extensor, supinator, and pronator muscles by having the examinee contract these muscles against manual resistance of the examiner. If

indicated, X-rays should include an anteroposterior and lateral views.

(5) *The Wrist and Hand.*—

(a) Palpate the wrist for tenderness in the anatomical snuff box often present in undiscovered fractures of the carpal navicular. Observe and compare range of motion of the wrists in flexion, extension, radial deviation, and ulnar deviation. Test muscle power in each of these positions.

(b) Inspect the palms and extended fingers for excessive perspiration, abnormal color or appearance, and tremor indicating possible underlying organic disease. Have the examinee flex and extend the fingers making sure the distal interphalangeal joints flex to allow the finger tips to touch the flexion creases of the palms. Observe the contour of the palm for possible atrophy of the thenar and hypothenar eminences, have the examinee touch the thumb tip to each finger tip and test the strength of pinch between the thumb and forefinger. With the hands pronated observe the contour of the dorsum of the hands for atrophy of the soft tissues between the metacarpals seen in disease or malfunction of peripheral nerves. With the fingers spread, test for strength, and interosseous muscle function by forcing the spread fingers together. Test also by pulling apart adjacent fingers against the resistance of the examinee. If indicated, anteroposterior and lateral X-rays of the wrist as well as anteroposterior and oblique views of the hand should be obtained.

(6) *The Hip.*—With the examinee stripped and standing, observe from behind for symmetry of the buttocks, the intergluteal cleft, and the infragluteal fold. Palpate the iliac crests and greater trochanters for symmetry. Have the examinee stand first on one foot and then the other, flexing the non-weight-bearing hip and knee and observing for ability to balance as well as for possible weakness of hip muscles or instability of the joint, as indicated by dropping downward of the buttock and pelvis of the flexed (i.e., the non-weight-bearing) hip. This, if present, is a positive Trendelenburg sign and necessitates X-ray evaluation. With the examinee supine, have examinee flex the hip, abduct, and adduct the hip and rotate the leg inward. Observe for hesitance in performing these motions, incomplete range of motion or facial evidence of pain on motion. Test muscle strength in each position. From the prone position, test for ability to extend each leg with knee extended and test for power in each hip in extension. If abnormalities are detected requiring X-rays, an anteroposterior view of *each* hip and a lateral view of *each* hip should be obtained so that the abnormal hip can be compared with the normal for possible evidence of disease or abnormality.

15-101. Roentgenographic Examination of Chest

(1) Roentgenographic examination of the chest shall be made as a part of the physical examination to

determine physical fitness for original entry into the service and for active duty, and of candidates for entrance to the Naval Academy as midshipmen or candidates for officer training, either as a part of the examination to determine their fitness for training or upon reporting to the School. If it is impracticable to obtain the roentgenographic examination or to have the examination read or to send the examination with the SF 88, a statement to this effect shall be made on the SF 88 with an explanation of why it is impracticable, with a request that roentgenographic examination be obtained if and when the applicant reports for active duty. The following entry shall be made on SF 600 of the individual concerned: "Chest X-ray study has not been conducted. It should be conducted at the first opportunity and a report thereof entered on block 46 of SF 88, and on SF 600." A recruit who has received roentgenographic examination of the chest during the physical examination for enlistment or induction with negative findings does not require another roentgenographic study upon arrival at a naval training station or Marine Corps recruit depot.

(2) Chest examinations of active duty personnel are required annually *only* for those with positive tuberculin skin tests as defined in 15-102(3)(c). Causes for further clinical study to determine the significance of lesions noted shall be those listed in article 15-20; such clinical study is best accomplished on the chest service of a naval hospital. Personnel who have X-ray findings of possible future significance shall receive this examination every 6 months, where possible, using 14- x 17-inch (35.46 x 43.18 cm) film.

(3) Roentgenographic examination of the chests of all Navy and Marine Corps personnel shall be made and the interpretation entered in the Health Record during the physical examination at the time of release from active duty or discharge from the service except instances of release from active duty with a view to immediate recall to active duty or discharge for immediate reenlistment.

(4) The results of roentgenographic examinations of the chest shall be recorded and reported as follows:

(a) *Identification and Filing of 14 x 17 Inch (35.46 x 43.18 cm) Roentgenograms.*—Entries shall be made in the Health Record/Health Jacket as indicated in articles 15-101(4)(c) and (d) below. Upon each roentgenogram must appear the following data:

(1) Identification of activity making examination, i.e., "NNMC Bethesda."

(2) The film number (place capital "C" after film number when a civilian employee is examined; capital "D" for dependents; and capital "O" to indicate other military), i.e., "999D."

(3) Date of examination, i.e., "3/5/80".

(b) *Disposal of 14 x 17 Inch (35.46 x 43.18 cm) Roentgenograms.*—The 14 x 17 inch (35.46 x

43.18 cm) roentgenograms shall be disposed of in accordance with SECNAVINST 5215.5 series.

(c) *Health Record.*—The place, date, film number, and a report of interpretation shall be entered on SF 600 or in block 46 of SF 88 if the purpose of the examination requires the preparation of an SF 88. The station and film number mentioned above must be entered without fail, for without this information the film cannot be located in the files.

(d) *Health Jacket (Civilian Employees).*—The place, date, film number, and report of interpretation shall be recorded in the health jacket of civilian employees.

(5) Requests for roentgenographic examinations and reports of roentgenographic examinations received from chiropractors shall be handled as follows:

(a) *New Examinations.*—Requests from chiropractors for new roentgenographic examinations shall not be honored.

(b) *Reports.*—Reports of roentgenographic examinations already taken shall be released to the patient upon request.

(c) *Copies.*—Requests for copies of roentgenographic films shall be honored. However, the beneficiary must pay for the copies.

15-102. Tuberculin Testing of Navy and Marine Corps Personnel First Reporting for Duty in Excess of 30 Days

(1) *Personnel To Be Tested.*—All personnel first entering for duty in the Regular Navy, the Naval Reserve, the Marine Corps, or Marine Corps Reserve for periods of duty in excess of 30 days, including duty for training, shall be tuberculin tested by the Mantoux method utilizing intermediate strength, stabilized, purified protein derivative (PPD) of tuberculin (5 tuberculin units equivalent).

(2) *Recording and Reporting.*—

(a) *Health Record Entry.*—The results of the test shall be entered in the Health Record on SF 601 under SENSITIVITY TESTS. The entry shall contain the place and date of test, the material and strength of dilution used, and the results recorded in millimeters of induration at the widest diameter transversely across the arm. The entry shall be completed in accordance with article 16-50.

(b) *Tuberculin Testing of Recruits, Midshipmen, and Other Special Personnel.* (MED 6224-1).—A record of the results of all tuberculosis screening among recruits, midshipmen, and other special personnel performed at Navy and Marine Corps recruit training centers and depots, the Naval Academy at Annapolis, and officer candidate schools of the Navy and Marine Corps shall be maintained and reported by letter to COMNAV MEDCOM after the end of each calendar year.

(3) *The Tuberculin Test.*—

(a) *Materials.*—The materials authorized for use in the tuberculin test are listed in BUMEDINST 6224.1 series.

(b) *Technique.*—The testing and interpreting shall be performed by adequately trained personnel of the Medical Department. Following aseptic preparation of the skin, an intradermal injection of one-tenth milliliter of the tuberculin solution shall be made upon the volar aspect of the *left* forearm. (The point of the needle should be plainly visible just within the outer layers of the epidermis.) The result, immediately after injection, should be a definite wheal, pale and sharply demarcated. Great care must be exercised to avoid subcutaneous injection. (Note.—When the tuberculin test is read, the forearm should be in a good light and flexed a little at the elbow. Tautness of underlying muscles may be sufficient to obliterate the redness and edema. It is well, also, to look across the forearm rather than down upon it. Pass the finger over the test area; the induration caused by the edema can be felt even when it does not produce an elevation that can be seen.)

(c) *Result of Test.*—The test shall be examined after an interval of not less than 48 hours nor more than 72. Redness without induration does not constitute a reaction. Response to injection is classified according to the extent of the induration measured in millimeters at its widest diameter transversely across the arm. The result is recorded in the following form: "Date Tuberculin test (state material and strength or dilution used) (results) mm. induration." Absence of induration is reported as "zero mm." When induration is present, the widest diameter measured transversely across the arm is recorded, using Arabic numerals; e.g., "17 Sep 72 PPD intermediate (5 TU), 6 mm induration." Induration of 10 mm or more will be regarded as a reactive test result while that of less than 10 mm will be regarded as nonreactive.

15-103. Testing Intraocular Tension

(1) *General.*—Approximately 2 percent of the general population, age 40 and over, have chronic simple or open angle glaucoma and are without symptoms. Routine tonometry performed annually on the age 35 and older individuals will detect hitherto undiagnosed glaucoma. This examination shall be performed by a physician, optometrist, or a technician who has received instruction in the proper performance and interpretation of this test.

(2) *Instrument.*—The Schiotz Tonometer estimates the intraocular pressure (IOP) or tension by the amount is plunger indents the cornea with a standard plunger weight.

(a) *Standardization.*—A new instrument with its case, testing plate, and weights should contain a certificate stating its correctness by a tonometer

testing station approved by the Committee on Standardization of Tonometers of the American Academy of Ophthalmology and Otolaryngology.

(b) *Care.* — The Schiötz Tonometer should be kept in its case, being protected from dust and injury. The standard weight and plunger should be removed and cleaned daily or between use on patients. Ether solution and a pipe cleaner can be used to clean the plunger column and the plunger. Thorough drying should be permitted prior to using on a patient.

(c) *Testing.* — With the instrument setting vertically on its individual test foot plate, there should be a scale reading of zero. If the plunger is not sticking and is freely movable and the test plate reading is not zero, then the instrument should be returned for repair and calibration.

(3) *Technique.* —

(a) *Anesthesia.* — One to two drops of proparacaine hydrochloride opthalmic solution, 0.5 percent are instilled into the eye by having the patient look up and by pulling the lower lid down. The patient is instructed to keep the eyes closed and to tell the examiner when the irritation from the topical anesthetic drops has ceased. Neither the patient nor the examiner should press on the eye at any time, and blotting of excess drops should be at the outer corner of the eye over bone.

(b) *Patient.* — Each patient should be informed that this is a test of the "water pressure" in the eye, that the anesthetic drops numb only the surface of the eye and will not affect the pupil or vision, and that the procedure is painless. As relaxation is essential for the validity of the test, the patient should be reclining in a comfortable position, collar loosened, and with both eyes open, fixing straight up on a target on the ceiling or looking at the extended thumb.

(c) *Use of the Schiötz Tonometer.* — The individual's lids are spread with one hand of the examiner so as to exert no pressure on the globe. The tonometer is brought in from the side and placed vertically on the center of the cornea in a free-riding position and the tonometer reading noted, first right eye (TOD), then left eye (TOS). At no time should the examiner obstruct the fixation of the patient nor touch the eye lashes with the tonometer. A satisfactory reading is obtained when the needle fluctuates with the pulse. Routinely, the 5.5 gm weight of the tonometer is used for the IOP. If the patient is not relaxed or squeezes the lids during the procedure, the readings are inaccurate and should be repeated again or at another time.

(d) *Calibration Scale or Conversion Table.* — The scale reading in units is converted into mm Hg Schiötz by using the conversion table and is recorded as TOD__mm Hg Schiötz (5.5) TOS__mm Hg Schiötz (5.5).

(4) *Normal Schiötz Intraocular Pressure.* — The upper limit of normal IOP is between 20 to 25 mm Hg or an average of 22 to 23 mm Hg Schiötz. Thus,

a tonometer reading of 3 with a 5.5 gm weight equals 24.4 mm Hg, or a tonometer reading of 5.5 with a 7.5 gm weight equals 23.8 mm Hg. As a check on the accuracy of the tonometer and the reading, the pressure with a 5.5 and a 7.5 gm weight on the same eye should be very nearly the same. When the 7.5 reading gives a higher pressure than the 5.5 reading, there is rigidity of the sclera present, and the IOP is lower than either of the two; when the 7.5 reading gives a lower pressure than the 5.5 reading, there is a decreased rigidity of the sclera, and the IOP is really higher than either of the two.

(5) *Conditions for Referral for Ophthalmologic Evaluation.* —

(a) A nonrelaxed or uncooperative individual.

(b) An individual with known sensitivity to proparacaine.

(c) Consistent elevation of IOP of greater than 25 mm Hg Schiötz in either eye.

(d) Consistent differences of IOP between the two eyes of 5 mm Hg Schiötz or more, even if both pressures are below 25 mm Hg Schiötz.

15-104. Eustachian Tube Patency Test (Valsalva's Maneuver Modified)

(1) *General.* — The "Valsalva's Maneuver Modified" is a test to evaluate the Eustachian tubes. A retracted tympanic membrane, a history of aerotitis media, or abnormalities about the ostia of the Eustachian tubes make it necessary to determine their patency.

(2) *Technique.* — With the tympanic membrane in view of the examiner, the examinee pinches the nostrils closed with the fingers of one hand, shuts the lips tightly, and tries to exhale forcefully. Positive pressure is produced in the nasopharynx and air will enter the middle ear cavity, if the Eustachian tube is patent. The examiner is able to note a movement of the tympanic membrane caused by the increased convexity in Shrapnell's area in the posterior superior quadrant of the membrane.

(3) *Interpretation.* — An individual who is unable to perform the "Valsalva's Maneuver Modified" should not be assigned to duties involving flying.

15-105. Special Examination Requirements

(1) This article establishes guidelines relative to the additional medical information often required in connection with the physical examination of applicants for appointment to commissioned grade, enrollment in officer candidate training programs, or entry into various special programs.

(2) All naval medical examining facilities and/or medical examiners are directed to ensure that reports of medical examination (SF 88 and 93) are complete and contain adequate evaluation of each defect noted, prior to submission of the reports to cognizant reviewing authorities.

(3) The following enumerates certain conditions,

defects, and items of personal history which require thorough evaluation, or report desired in each instance:

Each physical examination shall be reviewed for accuracy and completeness by the senior enlisted member assigned to the Physical Examination Section.

In block 73 of the Report of Medical Examination (SF 88), the following entry will be made:

The physical examination has been administratively reviewed for completeness and accuracy.

Signature

Rate

Date

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

Item	Examination and information denied
ALBUMIN, findings or history of.	Two daily specimens of urine for 3 days tested for albumin only, report of. The 1st specimen to be collected upon arising and the 2d in the afternoon. Report positive findings of albumin in mgm percent. If positive albumin persist, refer to article 15-16(1)(a) for 24-hour urine protocol.
AMPUTATION	Submit photographs for review.
ASTHMA, history of subsequent to age 12.	Detailed report of asthma and other allergic conditions and a statement from cognizant physician on (1) number and approximate dates of attacks of asthma, asthmatic bronchitis, or other allergic manifestations; (2) signs, symptoms, and duration of each attack; and (3) type and amount of broncho-dilating drugs used, particularly adrenalin, ephedrine, and aminophylline.
BACKACHE, back injury or wearing of back brace, history of.	Current orthopedic consultation and report on strength, stability, mobility, and functional capacity of back. Report of appropriate X-rays to be accomplished by a qualified physician. Transcript of any treatment from cognizant physician.
BLOOD PRESSURE, elevated findings or history of.	Repeated pulse and blood pressure (sitting position) readings in the a.m. and p.m. for 3-5 days without prolonged rest or any sedation. Completion of all sections of SF 88 items 57 and 58.
COLOR PERCEPTION defect.	Farnsworth Lantern examination and report of color perception.
CONCUSSION	See HEAD INJURY.
CONVULSIONS or SEIZURES, history of.	Neurological consultation and electroencephalogram. Transcript of any treatment from cognizant physician.
DIABETES, family history of in parent, sibling, or more than one grandparent.	<i>Standard single-dose oral 100GM glucose tolerance test</i> (after assurance that subject's carbohydrate intake has been liberal for several days before the test) with notation of the fasting, $\frac{1}{2}$ -hour, 1-hour, 2-hour, and 3-hour blood glucose values and concomitant tests for glycosuria. OR <i>Tolbutamide response test</i> (after assuring that the subject's carbohydrate intake has been liberal for several days before the test) with notation of the fasting, 20-minute, and 30-minute blood sugar values. <i>NOTE:</i> When either of the above tests is conducted, indicate in the report the method of blood sugar determination and the normal values of the test used.
DIZZINESS or FAINTING SPELLS, history of.	Neurological consultation.
ENURESIS or history of into late childhood or adolescence.	Comment on applicant's affirmative reply to question "bed wetting" to include number of incidents and age at last episode.
FLATFOOT, symptomatic finding or history of.	Current orthopedic consultation with detailed report on strength, stability, mobility, and functional capacity of foot. Report of appropriate X-rays to be accomplished by a qualified physician.
GLAUCOMA	Current ophthalmology consultation to include tonometry and field of vision where indicated.
GLYCOSURIA, finding or history of.	See DIABETES.
HAY FEVER, history of.	Detailed report of hay fever and other allergic conditions and a statement from the cognizant personal physician on (1) number, severity, and duration of attacks of hay fever or any other allergic manifestations, and (2) type and amount of drugs used in treatment thereof.

Item	Examination and Information desired
HEADACHES, frequent or severe, history of.	Neurological consultation.
HEAD INJURY with loss of consciousness in past 5 years, history of.	Electroencephalogram; neurological consultation; clinical abstract of treatment from cognizant physician.
HEMATURIA, history or finding of.	Medical consultation with evaluation report, including appropriate laboratory studies and/or complete urological evaluation if examining physician feels indicated.
HEPATITIS, history of.	Serum bilirubin and bromsulphalein retention.
JAUNDICE, history of in past 5 years.	Serum bilirubin and bromsulphalein retention.
JOINT, KNEE, internal derangement, history of.	Current orthopedic consultation and report on strength, stability, mobility, and functional capacity of knee. Report of appropriate X-rays together with comparative mensuration of the thighs, knees, and legs, to be accomplished by a qualified physician.
JOINT, SHOULDER, dislocation, history of.	Current orthopedic consultation and report on strength, stability, mobility, and functional capacity of shoulder. Report of appropriate X-rays to be accomplished by a qualified physician.
MALOCCLUSION, TEETH.	Report of examination by a dentist with comment as to whether incisal and masticatory function is sufficient for satisfactory ingestion of the ordinary diet, and statement as to presence and degree of facial deformity with jaw in natural position.
MASTOIDECTOMY, bilateral, history of.	Current ENT consultation to include audiogram.
MOTION SICKNESS, history of.	Detailed report of all occurrences of motion sickness (such as air, train, sea, swing, carnival-ride), and the age at time of last occurrence.
NASAL POLYPS, history of.	Ear, nose, and throat consultation, with comment as to date polyp removed if no longer present. Detailed report by cognizant physician on allergic history and manifestation to include required medication.
SKULL FRACTURE, in past 5 years, history of.	See HEAD INJURY.
SLEEPWALKING, beyond childhood, history of.	Detailed comment by physician. Comment on applicant's affirmative reply to question "been a sleepwalker" to include number of incidents and age at last episode.
SQUINT	Examination for degree of strabismus and presence of complete and continuous 3d degree binocular fusion. Request completion of SF 88 items 62 and 65 and notation of degree of strabismus.
STUTTERING or STAMMERING, finding or history of.	Report of Reading Aloud Test in article 15-23(1)(i).
TRICK KNEE, history of.	See JOINT, KNEE.
VERTEBRA, fracture or dislocation, history of.	Current orthopedic consultation and report on strength, stability, mobility, and functional capacity of spine. Report of appropriate X-rays to be accomplished by a qualified physician.

(4) It is desired that a detailed report of a consultation by a qualified neuropsychiatrist for evaluation of maturity, emotional stability, and suitability for commissioned service be obtained and submitted with the SF 88 and 93 in the following instances:

(a) When any one of the following questions in Items 9 and 11 on the SF 93 is checked in the affirmative by an applicant:

9. Have you ever—
Attempted suicide.

11. Have you ever had or have you now—
Loss of memory or amnesia.

(b) When any combination of two or more of the following questions in items 9, 10, and 11 on the SF 93 are answered in the affirmative and ques-

tioning by the examiner reveals that any one of the conditions was present beyond early childhood:

9. Have you ever—
Been a sleepwalker.

10. Do you—
Stutter or stammer habitually.

11. Have you ever had or have you now—
Bed wetting since age 12.

(c) When the examining physician feels that the individual's response to further questioning is inappropriate to any of the following questions in item 11 on the SF 93:

11. Have you ever had or have you now—
Frequent trouble sleeping.
Depression or excessive worry.
Nervous trouble of any sort.

Chapter 16

HEALTH RECORD

Sections

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Section I. GENERAL

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16-1. Purpose of the Health Record

(1) The purpose of the military Health (medical and dental) Record is to provide an individual chronological record of medical and dental examinations, evaluations, and treatment afforded members of the naval service. The record has significant current and long-term medicolegal value to the member concerned, the member's beneficiaries, and the Government. Accuracy and completeness in recording and filing record entries are of the utmost importance.

16-2. General Requirements

(1) Health care treatment records of Personnel Reliability Program personnel must be identified in accordance with BUPERSINST 5510.11 series for naval personnel, and Marine Corps Order (MCO) 5510.7 series for Marine Corps personnel, using form NAVPERS 5510/1, Record Identifier for Personnel Reliability Program. Health care treatment records include Health Records (medical and dental), inpatient records, and any adjunct records (e.g.,

psychiatric records) which are maintained separately from the primary treatment record. Also included are health care treatment forms temporarily separated from the primary treatment record (e.g., SF 600, SF 513, etc.). In every instance, NAVPERS 5510/1 must be the topmost form in the treatment record or attached to the treatment forms.

(2) All dates recorded on the component forms of the Health Record shall be entered in the following sequence: day (numeral), month (in capitals, abbreviated to the first three letters), and year (two or four numerals), i.e., 4 JAN 71 or 4 JAN 1971.

16-3. Verification of the Health Record

(1) As a minimum, Health Records shall be verified annually by medical personnel having custody of the record. Whenever practicable, verification of the Health Record shall coincide with that of the service record and pay record, and with major evolutions such as required annual special duty physical examinations. In addition, verification shall be accomplished upon reporting and upon detachment from a duty station, and at the time of physical examination. Annual verification of Marine Corps Reserve Health Records shall be accomplished for class II reservists in conjunction with the audit conducted concurrently with the annual screening of the Ready Reserve.

(2) Each record shall be carefully reviewed. Any errors or discrepancies noted shall be corrected. During each verification, special attention shall be given to:

(a) Ensure accuracy, completeness, and legibility of all identifying information entered on the Health Record jacket or Health Record forms including: name; social security number; designator or military occupational specialty; date and place of birth; sex; and grade/rate.

(b) Verify blood group and RH factor, and, if applicable, drug allergies and Personnel Reliability Program status.

(c) Ensure that forms are filed in the proper order, and, if the individual is departing, ensure that all forms have been filed in the Health Record. Particular attention shall be given to ensuring that all SF 600's, laboratory and X-ray reports, and consultation sheets are included. In addition, NAVMED 6150/7, Health Record Receipt, File Chargeout, and Disposition Record, shall be completed and retained in accordance with instructions on the form.

(3) A signed entry to the effect that the verification has been accomplished shall be recorded in the designated space on the left, inside leaf of the Health Record jacket.

16-4. Release of Information

(1) The policy on release of information

from Health Records is set forth in chapter 23, section III.

16-4A. Contents of the Health Record

(1) Each member's Health Record shall consist of a DD Form 722, Health Record Jacket, containing the following health care forms:

(a) Left Side; Dental.-

(1) DD Form 722-1, Dental Folder.- When the dental folder is maintained and transferred with DD Form 722, it shall be fastened to the left side of the Health Record jacket using the metal fastener provided. (See art. 16-18(1) for an explanation of when DD Form 722-1 may be maintained separately from DD Form 722.)

(2) A list of forms authorized for filing in the dental folder is provided in art. 6-109.

(b) Right Side, Medical.- The following forms shall be arranged in top-to-bottom sequence on the right side of the Health Record jacket. Like numbered forms shall be filed grouped together with the most recent placed on top of each previous form, unless specified otherwise below. Except for the forms prescribed below, no other forms or documents shall be incorporated in the Health Record unless approved by COMNAVMEDCOM as provided for in article 16-4A(2) below. Pertinent health care information from local or civilian practitioner forms may be transcribed onto SF 600 for incorporation in the Health Record.

(1) NAVPERS 5510/1, Record Identifier for Personnel Reliability Program.- When required, shall always be the topmost form filed on the right side of the Health Record jacket. See also art. 16-2(1), BUPERSINST 5510.11 series, and MCO 5510.7 series.

(2) SF 600, Chronological Record of Care (Special-Hypersensitivity).- When required, shall always be filed immediately below NAVPERS 5510/1. If NAVPERS 5510/1 is not required, this form shall be the topmost form in the Health Record jacket. (See art. 16-48(6).)

(3) SF 600, Chronological Record of Care (Special-Blood Grouping and Typing Record).- Shall always be filed immediately below the above two forms. If the above two forms are not required, this form shall be the topmost form filed in the Health Record jacket.

(4) SF 600, Chronological Record of Care.- All non-special SF 600's shall be filed (grouped) together immediately below the special SF 600's. See also section IX.

(5) Standard Form 558, Emergency Care and Treatment.- Shall be interfiled with the nonspecial SF 600's since these forms document similar care. SF 558 shall be filed immediately above the SF 600 containing the last dated entry prior to the date on the SF 558. See also BUMEDINST 6320.61 series.

(6) SF 513, Consultation Sheet.- Shall be filed immediately below the SF 600 or SF 88 to which it pertains.

(7) NAVMED 6150/3, Sick Call Treatment Record.- No longer required, but previously completed forms shall be maintained in the Health Record jacket.

(8) DD Form 771, Eyewear Prescription.- See art. 16-69.

(9) SF 502, Narrative Summary.- See art. 16-65.

(10) SF 539, Abbreviated Medical Record.- See art. 16-66.

(11) SF 516, Operation Report.- When used to record outpatient surgery.

(12) SF 517, Anesthesia.- When completed in conjunction with outpatient surgery. Attach to the corresponding SF 516.

(13) SF 522, Request for Administration of Anesthesia and for Performance of Operations and Other Procedures.- When completed in conjunction with outpatient surgery. Attach to the the corresponding SF 517.

(14) NAVMED 6300/2, Request and Consent for Sterilization.- When completed in conjunction with outpatient surgery. Attach to corresponding SF 516.

(15) NAVMED 6300/3, Statement of Need for Therapeutic Abortion.- When abortion is accomplished on an outpatient basis. Attach to corresponding SF 516.

(16) NAVMED 6300/4, Consent for Therapeutic Abortion.- When abortion is accomplished on an outpatient basis. Attach to corresponding SF 516.

(17) SF 601, Immunization Record.- See section X.

(18) DD Form 1141, Record of Occupational Exposure to Ionizing Radiation.- When required. See also section XV.

(19) NAVMED 6224/1, TB Contact/Converter Followup.- When required. See also BUMEDINST 6224.1 series.

(20) SF 602, Syphilis Record.- See section XI.

(21) SF 512A*, Plotting Chart.- Blood Pressure.

(22) SF 518*, Blood or Blood Component Transfusion.

(23) SF 524*, Radiation Therapy.

(24) SF 525*, Radiation Therapy Summary.

(25) SF 526*, Interstitial/Intercavitary Therapy.

(26) SF 527*, Manual Muscle Evaluation.

(27) SF 527A*, Joint Motion Measurements.

(28) SF 528*, Muscle and/or Nerve Evaluation.- Manual and Electrical: Upper Extremity.

(29) SF 529*, Muscle and/or Nerve Evaluation.- Manual and Electrical: Trunk, Lower Extremity, Face.

(30) SF 530*, Neurological Examination.

(31) SF 531*, Anatomical Figure.

(32) SF 533*, Prenatal and Pregnancy.

(33) SF 541*, Gynecologic Cytology.

(34) NAVMED 6100/1, Medical Board Report Cover Sheet.- When required. See also arts. 18-23 thru 18-26, 18-28 thru 18-32, and BUMEDINST 1910.2 series.

(35) NAVMED 6100/2, Medical Board Statement of Patient.- When required. Attach to corresponding NAVMED 6100/1. See also arts. 18-22, 18-26, and BUMEDINST 1910.2 series.

(36) NAVMED 6100/3, Medical Board Certificate Relative to a PEB Hearing.- When required. Attach to corresponding NAVMED 6100/1. See also arts. 18-12, 18-26, and BUMEDINST 1910.2 series.

(37) SF 88, Report of Medical Examination.- See section VII.

(38) SF 93, Report of Medical History.- Attach to corresponding SF 88. See also section VIII.

(39) NAVMED 6410/9, Anthropometric Data Record.- When required. Attach to corresponding SF 88.

(40) NAVMED 6120/1, Competence for Duty Examination.- When required. See also BUMEDINST 6120.20 series.

(41) NAVMED 6120/2, Officer Physical Examination Questionnaire.- See art 15-52.

(42) NAVMED 6120/3, Annual Certificate of Physical Condition.- When required. See also arts. 15-54 and 15-84.

(43) NAVMED 6150/2, Special Duty Medical Abstract.- See section XIV.

(44) NAVMED 6150/4, Abstract of Service and Medical History. See section XIII.

(45) NAVMED 6420/1, Report of all Diving Accidents.- No longer required, but previously completed forms shall be maintained in the Health Record jacket.

(46) SF 520, Electrocardiographic Record.- Baseline and most recent electrocardiograms only.

(47) DD Form 2215, Reference Audiogram.- Baseline audiogram only. See also OPNAVINST 6260.2 series.

(48) DD Form 2216, Hearing Conservation Data.- When required. See also OPNAV INST 6260.2 series.

(49) SF 519, Radiographic Report.- Backing sheet for mounting SF 519A.

(50) SF 519A, Radiographic Report.- When completed in conjunction with outpatient care. Attach to SF 519 in chronological order, most recent on top of each previous report.

(51) SF 515, Tissue Examination.- When completed in conjunction with outpatient care.

(52) SF 545, Laboratory Report Display.- Backing sheet for mounting SF's 546 thru 557.

(53) SF's 546 thru 557, Laboratory Reports.- When completed in conjunction with outpatient care. Attach to SF 545 in chronological order, with most recent on top of each previous report.

(54) DD Form 2005, Privacy Act Statement-Health Care Records.- One copy, signed by the service member, must be filed in each Health Record jacket.

(55) Disclosure accounting documents required by the Privacy Act.- See art. 23-72.

*When used to record outpatient care.

(c) Other Forms, Special Filing Requirements.-

(1) DD Form 2064, Certificate of Death (Overseas), or civil death certificate.- Upon the death of a service member, the appropriate death certificate shall be completed in accordance with chapter 17, section II, the Health Record shall be closed in accordance with chapter 16, section III. Immediately before closing and forwarding the Health Record, a copy of the death certificate shall be filed as the topmost form on the right side of the Health Record jacket.

(2) SF 503, Autopsy Protocol.- When prepared. Attach to corresponding death certificate.

(3) SF 532, Authorization for Autopsy.- When required. Attach to corresponding SF 503.

(4) SF 523A, Disposition of Body.- When required. Attach to corresponding SF 523.

(5) SF 523B, Authorization for Tissue Donation.- When required. Attach to corresponding SF 523.

(6) NAVMED 6150/7, Health Record Receipt, File Chargeout, and Disposition Record.- A NAVMED 6150/7 shall be prepared for each Health Record by Medical Department personnel having custody of the Health Record. NAVMED 6150/7 shall be placed inside the Health Record jacket when the Health Record is in file and removed for use as a file chargeout form when the Health Record is out-of-file. See also form NAVMED 6150/7 and art. 16-27(3) for additional instructions concerning use as a disposition record.

(2) When prior approval is obtained from COMNAVMEDCOM (MEDCOM-312), other SF, DD, and NAVMED forms, as well as forms of other Federal medical facilities, documenting health care may also be filed in the Health Record. Additionally, when prior approval is obtained from COMNAVMEDCOM, a limited number of the forms listed in art. 16-4A(1) above (e.g., SF 600) may be overprinted to capture additional health care information. See also NAVMEDCOMINST 5210.8 series.

Section II. OPENING THE HEALTH RECORD

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16—5. General

(1) A Health Record shall be opened whenever an individual becomes a member of the naval service, whenever a member on the retired list is returned to active duty, or in the event the original record has been lost or destroyed. All applicable spaces on each of the component forms designated for personal identification data shall be completed. Official abbreviations of grade or rating shall be used. The social security numbers of officers shall be followed by the designator code or MOS, as appropriate, except on the SF 88 where the designator code or MOS will follow the grade and component in block 2.

(2) If an individual is appointed, enlisted, or reenlisted with disqualifying defects which have been waived by NAVMILPERSCOM or MARCORPS, the description of each defect with authority for waiver shall be entered on the SF 88 and SF 600.

(3) When the initial Health Record is opened it shall consist of (a) DD 722—1 (Dental Folder) containing the original SF 603, and (b) DD 722 (Health Record Jacket) containing component forms assembled in top—to—bottom sequence as follows: SF 600, SF 601, SF 88, SF 93, and NAVMED 6150/4. For inactive Reserves recalled to active duty (including those affiliated with Ready Reserve units), the entire Health Record shall be requested as follows:

(a) *Navy*.—Naval Reserve Personnel Center, 4400 Dauphine St., New Orleans, LA 70149.

(b) *Marine Corps*.—Marine Corps Reserve Support Center, 10950 El Monte, Overland Park, KS 66211.

(4) For individuals who have had prior service and who have been discharged, order their Health and Dental Records from the National Personnel Records Center, 9700 Page Blvd., St. Louis, MO 63132. When ordering the records, use only the DD Form 877 (Request for Medical/Dental Records for Information). See article 23—54.

16—6. Officers

(1) A Health Record shall be opened at the time of acceptance of appointment for individuals appointed from civil life, and the record shall be forwarded to the initial place of active duty.

(2) If the member is appointed and retained on inactive duty, the record shall be disposed of as follows:

(a) Class II Marine Corps reservists—forward to or retain at the Organized Marine Corps Reserve unit to which assigned.

(b) Class III Marine Corps reservists—forward with the service record to Marine Corps Reserve Support Center, 10950 El Monte, Overland Park, KS 66211.

(c) Naval reservists assigned to a drilling unit of the Selected Reserve in pay or nonpay status—forward to unit to which assigned.

(d) Naval reservists assigned to a specialist or composite unit or 19XX designator—deliver to commanding officer for transmittal in same package with service record to cognizant area coordinator designated by the Chief of Naval Operations (CNO).

(e) Naval reservists not included in (c) or (d) above—deliver to the commanding officer for transmittal with the service record to the Naval Reserve Personnel Center, 4400 Dauphine St., New Orleans, LA 70149.

(3) When a midshipman or enlisted member is appointed to commissioned or warrant grade, the existing Health Record shall be continued in use. The activity having custody of the record at the time of acceptance of appointment shall (a) make necessary entries to indicate the new grade and the designator or MOS and (b) prepare summary information entries on SF 600 and NAVMED 6150/4 to include date, place, and grade to which appointed.

16—7. Naval Academy Midshipmen, Officer Candidates, and Student Officers

(1) Health Records of civilian candidates selected for appointment to the Naval Academy shall be prepared at the Naval Academy at the time of appointment.

(2) Health Records for civilian applicants selected for an officer candidate program shall be opened upon enrollment in the particular program. The Health Record shall be opened in accordance with article 16—5 except for NROTC applicants. For NROTC applicants: (a) the DD 722 (Health Record Jacket) containing copies of the SF 88 and 93 shall be prepared at the time of enrollment; (b) the SF 600 and NAVMED 6150/4 and the SF 601 shall be prepared and included in the DD 722 by the Professor of Naval Science as the need for such arises; and (c) the DD 722—1 (Dental Folder) and original SF 603 shall be completed either at the time of the precommissioning physical examination or the first

annual physical examination, whichever occurs first.

(3) The existing Health Record shall be continued in use when Navy and Marine Corps enlisted members are (a) assigned to the Naval Preparatory School, (b) appointed to the Naval Academy, or (c) enrolled in an officer candidate program. Entries shall be made by the activity having custody of the record to indicate the change in the member's status.

16-8. Enlisted Members

(1) The Health Record shall be opened by the activity executing the enlistment contract upon original enlistment in the naval service. An exception to the foregoing are those members who are enlisted or inducted and ordered to immediate active duty at a recruit training facility. In these instances the Health Record shall be opened by the naval training center or MARCORPS recruit depot, as appropriate.

(a) In all instances, the original SF 88 and SF 93 shall be attached to the enlistment contract and forwarded with other entrance documents to NAVMILPERSCOM or MARCORPS. Copies of the SF 88 and SF 93 shall be forwarded to the appropriate naval training center or recruit depot.

These forms with other applicable Health Record forms shall be incorporated into the member's Health Record.

(b) The Health Record of persons who are enlisted or reenlisted in a Reserve component and retained on inactive duty shall be disposed of as follows:

(1) Class II Marine Corps reservists—forward to the Organized Marine Corps Reserve unit to which assigned.

(2) Class III Marine Corps reservists—forward with the service record to Marine Corps Reserve Support Center, 10950 El Monte, Overland Park, KS 66211.

(3) Naval reservists assigned to a drilling unit of the Selected Reserve in pay or nonpay status—forward to unit to which assigned.

(4) Naval reservists assigned to specialist or composite unit and Naval Reserve officer school personnel—deliver to commanding officer for transmittal in the same package with the service record to the cognizant area coordinator designated by CNO.

(5) Naval reservists not included in (3) or (4) above—forward to the commanding officer for transmittal with the service record to the Naval Reserve Personnel Center, 4400 Dauphine St., New Orleans, LA 70149.

Section III. CLOSURE OF HEALTH RECORD

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16-9. General Instructions

(1) The Health Record shall be closed when a member (a) dies, (b) is discharged, (c) resigns, (d) is released to inactive duty, (e) is retired, (f) is transferred to the Fleet Reserve and released to inactive duty, (g) is declared missing or missing in action, (h) is declared a deserter, and (i) when an officer candidate or midshipman is disenrolled.

(2) Closing entries shall be recorded on NAVMED 6150/4. Entries shall include the (a) date of separation, (b) title of servicing activity, and (c) explanatory circumstances as may be indicated.

(3) Except as otherwise provided in the following articles, the entire Health Record including the DD 722 (Health Record Jacket) and the DD 722-1 (Dental Folder) will be delivered to the command maintaining the member's service record (no later than the day following separation) for inclusion in and transmittal with the member's service record. Additionally, upon release, discharge, or retirement, the member will be provided with a copy of the separation physical examination (SF 88) and a copy of the most recent Report of Medical History (SF 93).

(4) Prior to forwarding, the Health Record shall be verified in accordance with article 16-3. Care should be taken to ensure that the Dental Folder and all health care treatment forms are included.

16-10. Disappearance, Missing, or Missing in Action

(1) Whenever a member disappears and the available information is insufficient to warrant an administrative determination of death, a summary of the relevant circumstances shall be entered on the SF 600. The entry shall include circumstances pertaining to the presumed disappearance of the individual, as supported by the available evidence; i.e., missing or missing in action. The record shall then be closed and handled as in article 16-9(3).

16-11. Desertion

(1) When a member is officially declared a deserter, an explanatory entry of this fact shall be

recorded on the SF 600 and NAVMED 6150/4. The Health Record (including the Dental Record) shall be delivered to the commanding officer for inclusion in and transmittal with the member's service record for both Navy and Marine Corps personnel.

(2) A deserter shall be physically examined at the first activity assuming jurisdiction of the member following surrender or apprehension. A statement shall be prepared by the medical examiner setting forth the purpose and findings of the examination. A specific opinion about the member's physical fitness for confinement, and ability to perform active duty at sea, on foreign service, or in the field, as appropriate, shall be included in each instance. The statement shall be recorded on SF 600, for inclusion in the member's Health Record.

(3) Upon apprehension or surrender of a deserter, the commanding officer of the jurisdictional activity shall submit a request for the member's records to NAVMILPERSCOM or CMC, as appropriate. A separate request to BUMED for the member's Health Record is not required.

16-12. Discharge or Death

(1) Upon discharge and immediate reenlistment, the entire Health Record shall be retained in the field.

(2) Upon discharge, the Health Record shall be closed and handled as in article 16-9(3).

(3) Upon death of the member, proper closing entries shall be made and the Health Record, along with a copy of the death certificate, handled as in article 16-9(3).

16-13. Discharge of Member Convicted by Civil Authorities

(1) When discharge of a member convicted by civilian authorities is directed by COMNAVMIIPERSCOM or CMC, arrangements for the physical examination and report thereof shall be made by the member's commanding officer, or the cognizant area coordinator designated by CNO in whose area the member is confined. In the interest of precluding the incurrence of unnecessary travel by the examiner with attendant expense and loss of time from regular

duties, the physical examination may be conducted and reported by any of the following: (a) medical officer of the Armed Forces or other Federal Government agency, (b) penal institution physician, or (c) in the absence of the services of the foregoing listed physicians, a certificate signed by the official in charge of the penitentiary reflecting an opinion about the present state of health of the person to be discharged will ordinarily suffice. The original SF 88, or the statement received from the prison official, shall be filed in the Health Record in accordance with article 16-4A, and the Health Record shall then be closed and handled as in article 16-9(3).

16-14. Release to Inactive Duty

(1) The Health Record shall be closed (a) whenever members of the Reserve components are released from active duty, including active duty for training in excess of 30 days, (b) upon transfer to Naval or Marine Corps Reserve inactive duty from the Regular Navy or Marine Corps, and (c) upon transfer to the Fleet Reserve or Fleet Marine Corps Reserve and release to inactive duty.

(2) In all instances, the complete Health Record shall be forwarded as in article 16-9(3).

16-15. Retirement

(1) When, for any reason, a member of the naval service is placed on the retired list and released to inactive duty, or upon release to inactive duty of a retired member performing active duty, the Health Record shall be closed and handled in accordance with article 16-9(3).

16-16. Disenrollment of Midshipmen or NROTC Members

(1) *Midshipmen.*—When, for any reason, a midshipman's connection with the naval service is ter-

minated, the member's Health Record shall be closed and retired to NPRC, (MPR), GSA, St. Louis, MO 63132, in accordance with SECNAVINST 5212.5 series. This includes midshipmen who graduate from the Naval Academy but do not receive commissions. For midshipmen who retain a status in the naval service after disenrollment from the Naval Academy, the Health Record shall be forwarded to the member's prospective commanding officer.

(2) *NROTC.*—When, for any reason, an NROTC member's connection with the naval service is terminated, the member's Health Record shall be closed and retired to NPRC, (MPR), GSA, St. Louis, MO 63132, in accordance with SECNAVINST 5212.5 series. For members of the NROTC who retain a status in the naval service after disenrollment, the Health Record shall be forwarded to the member's prospective commanding officer.

16-17. Former Members Retained in Naval Hospitals and Medical Centers

(1) When a patient in a naval hospital or medical center is separated from the naval service, but subsequently retained as an inpatient for further treatment, the Health Record shall be closed on the effective date of separation and forwarded in accordance with article 16-9(3). In such instances a new Health Record shall not be prepared. However, upon disposition of the former member from the hospital, a copy of the clinical summary (SF 502 or SF 539) shall be forwarded for inclusion in the member's Health Record.

(2) A copy of a clinical summary prepared incident to the hospitalization of a member whose name is carried on the Temporary Disability Retired List shall be forwarded upon termination of hospitalization as follows: Navy—Naval Reserve Personnel Center, 4400 Dauphine St., New Orleans, LA 70149; or Marine Corps—Headquarters Marine Corps (Code MMSR), Navy Department, Washington, D.C. 20380.

Section IV. CUSTODY OF HEALTH RECORD

	Article
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16-18. Responsibility for Custody

(1) The Health Record shall be retained in the custody of the medical officer of the ship or station to which the member is attached. When the member is attached to a ship or station having a dental facility, the DD 722-1 containing the SF 603 shall be placed in the custody of the dental officer. On ships or stations having no medical officer, the Health Records may be placed in the custody of the Medical Department representative at the discretion of the commanding officer. In those instances where Medical Department personnel are not assigned, it shall be the responsibility of the commanding officer of the Medical Department facility providing medical support to assume custody of the Health Records of the members assigned to such activity. Service members shall not retain custody of their own Health Records. Wherever maintained, the Health Record shall be kept intact (except for the Dental Record as noted above). Separate files for Health Records and Health Record treatment forms (e.g., SF 601, Immunization Record) are not authorized.

(2) Health Records shall be subjected to inspection at any time by the commanding officer of the Medical Department facility, superiors in the chain of command, the fleet medical officer, or other duly authorized medical inspectors. Otherwise, the Health Record is for official use only and adequate security and custodial care are required.

(3) When a Health Record is received or transferred, it shall be verified in accordance with article 16-3. Appropriate corrective action shall be taken if additional data is required.

(4) For each Health Record received, a NAVMED 6150/7, Health Record Receipt, File Chargeout, and Disposition Record, shall be initiated and maintained by Medical Department personnel having custody of the Health Record. (See also art. 16-4A(1)(c)(6).)

(5) All signatures in the Health Record shall be signed in black or blue-black pen. The name, grade, or rating of Medical Department officers and other authorized Medical Department personnel making entries in the Health Record shall be typed, printed, or stamped under the signature. Stamped facsimile

signatures shall *not* be used on any medical or dental forms of the Health Record. In signing, the individual assumes responsibility for the correctness of the entry.

(6) The Medical Department representative of the ship or station has the authority to approve or enter reason for disapproval of all entries made on medical forms of Health Records in their custody.

(7) If an erroneous entry is noted on review of the Health Record, a single diagonal line shall be drawn through it, *making sure not to obliterate any part of the entry*. An additional entry shall be made on an SF 600 showing wherein and to what extent the original entry is erroneous. (See also art. 16-74, illustration 3B and art. 23-73.) On the left side of the form containing the erroneous entry, the date and SF 600 page number of the correcting entry, as well as the signature and grade/rate of the Medical Department representative making the change, shall be recorded.

(a) If an error is made at the time a hand written entry is being placed on a Health Record form, a single line shall be drawn through the erroneous word or phrase, the person making the entry shall initial above the error, and continue with the entry (see art. 16-74, illustration 3B).

(b) Corrections of typographical or clerical errors (i.e., transposition of numbers or letters, etc.) are authorized.

(8) Each medical officer or Medical Department representative is responsible for the completeness of any required Health Record entries while the record remains in his or her custody.

16-19. Cross-Servicing Health Records

(1) *Policy.*—The Army, Air Force, and Coast Guard have Health Records for their personnel. In general, their procedures for maintaining and transferring the records are similar to those of the Navy. Full cross-servicing of Health Records is intended. However, when Army, Navy, Air Force, and Coast Guard procedures differ, Navy custodians of Health Records shall comply with Navy instructions.

Similarly, Army, Air Force, and Coast Guard will follow their procedures.

(2) Procedure When Army and Air Force Personnel Are Treated At Navy Facilities. —

(a) When Army and Air Force personnel are attached to Navy facilities for primary medical care (sick call) or dental care, the Navy medical facility will assume custody of their Health Records if Army and Air Force medical personnel are not available.

(b) When Army and Air Force personnel are treated at naval facilities, their Health Records shall be requested if necessary for their treatment. If the Health Record is not available, records of treatment shall be forwarded to the member's duty station for insertion into the Health Record.

(3) Procedure When Navy and Marine Corps Personnel Are Treated at Army and Air Force Facilities. —

(a) Commanding officers shall forward Navy Health Records to Army and Air Force medical officers concerned when (1) members of the naval service are attached for primary medical or dental care to Army or Air Force facilities, or (2) the records are required in connection with treatment.

(b) Army and Air Force health care treatment forms may be filed in Navy Health Records if prior approval is obtained from BUMED. (See art. 16-4A(2).)

(4) When Active Duty Coast Guard Personnel Are Hospitalized at Navy Facilities. —

(a) When active duty Coast Guard personnel are hospitalized at Navy facilities, commanding officers shall request the patient's Health Records be forwarded whenever they are needed in connection with treatment.

(b) When active duty Coast Guard personnel are discharged from a Navy facility following a period of hospitalization, the original signed narrative summary shall be inserted in the Health Record and the Health Record returned to the unit or station where the member is assigned. If the Health Record is not available, the narrative summary shall be furnished to the unit or station where the member is assigned for insertion in the Health Record. In either instance, a copy of the narrative summary shall be furnished to the Commandant (G-KMA/63), U.S. Coast Guard, Washington, D.C. 20590.

16-20. Transfers to Ships or Stations

(1) When a member is transferred, the medical officer or Medical Department representative shall verify the Health Record in accordance with article 16-3 and ascertain that the member has been processed in accordance with the provisions of article 15-57. When the Dental Folder has not been maintained on file with the Health Record Jacket, it shall be included prior to transfer.

(2) Officers ordered to active duty or transferred to another ship or station will be allowed to deliver

their Health Record; otherwise, the record shall be forwarded via official channels. When an enlisted member is transferred, the Health Record shall be forwarded with the service record and pay record to the receiving command. For exceptions see (3) and (4) below.

(3) When a member is ordered to participate in a foreign service expedition and the possibility of loss or seizure of the record makes it inadvisable that the record accompany the member, it shall be retained in the staging area. Interim entries shall then be recorded on an SF 600 or 603, for subsequent insertion in the Health Record.

(4) If a member is ordered to independent duty where there is no Medical Department representative or if the duty destination is not obvious, the Health Record shall be kept with the member's service record.

(5) When practicable, the Health Record shall accompany any member conveyed by the Military Sealift Command.

(6) In instances of unauthorized absence prior to departure of a ship or other unit on an extended assignment, the Health Record of the absentee shall be delivered to the commanding officer for inclusion in the member's service record.

(7) Upon receipt of notification concerning the apprehension or voluntary return to naval custody of an absentee who because of circumstances cannot be returned to the assigned unit, immediately transfer the Health Record to the intermediate activity or advise them about the location of the record.

(8) When a patient is received aboard ship for the purpose of transportation, the medical officer or the Medical Department representative shall maintain the Health Record. It is essential that the record of the chain of events remain unbroken; therefore, a patient received from transfer must be taken up as "From Transfer" with the same diagnosis under which transferred. Any subsequent entries or changes of diagnosis shall be recorded in the prescribed manner.

16-21. Hospitalization at Naval Medical Facilities

(1) When a patient is transferred to a naval medical facility the Health Record shall be delivered with the patient.

(2) If a member on active duty is admitted directly to a naval medical facility while away from the member's present duty station, the Health Record shall be forwarded as soon as practicable to the admitting facility.

(3) Upon completion of treatment, the Health Record shall be returned to the member's duty station. However, the member shall not be retained after completion of treatment solely for the completion of any pending entries or adjunct reports. In such instances appropriate information will be included on the transfer authorization to indicate that the member's Health Record or

related reports will be furnished as soon as practicable.

(4) When a member is discharged from treatment at a naval hospital and is directed to proceed home and await final action on the recommended findings of a physical evaluation board, an entry to this effect shall be recorded in the Health Record.

16-22. Hospitalization and Transfer to Federal Medical Facilities Other Than Naval

(1) Upon transfer of a Navy or Marine Corps patient to any Federal medical facility to which a naval medical unit or Navy liaison officer is attached, the Health Record shall accompany the patient, or be forwarded as soon as practicable.

(2) Upon transfer of a Navy or Marine Corps patient to an Armed Forces or a Federal medical facility to which no naval medical unit or Navy liaison officer is attached, the following shall apply:

(a) *Army or Air Force Facilities.*—The Health Record shall accompany the patient, or be forwarded as soon as practicable, for direct cross-servicing (see art. 16-19). The Health Record is returned to the member's duty station upon disposition of the member.

(b) *Veterans Administration Hospitals.*—The Health Record of a patient transferred to a VA hospital shall be forwarded to the appropriate authority designated in BUMEDINST 6320.11 series. The activity receiving the Health Record shall continue maintenance thereof until disposition of the patient is accomplished. Prior to forwarding the record, an entry shall be recorded on SF 600 to indicate the name and location of the VA hospital to which the patient has been transferred. If the member has appeared before a physical evaluation board, the recommended findings shall be recorded on the SF 600. The VA hospital shall be furnished with a duplicate or photocopy of the current SF 600 for inclusion in the member's Clinical Record at that activity. Upon completion of treatment or separation from the naval service, a clinical summary will ordinarily be forwarded by the VA hospital to the activity maintaining the Health Record. In such instances the Health Record will be forwarded by the cognizant activity to the member's next duty station or, if closed, forwarded in accordance with article 16-9(3).

16-23. Emergency Hospitalization and Direct Admission at Federal Medical Facilities Other Than Armed Forces

(1) When it is expected that hospitalization will not exceed 7 days and the unit to which the member is attached is not scheduled to depart the area, the Health Record shall be retained by the activity having custody. (See art. 16-19.)

(2) When the parent command is not expected to remain in the area during the period of hospitalization, or when it is anticipated that the hospitalization will exceed 7 days, the Health Record shall be forwarded to the cognizant office of medical affairs (see BUMEDINST 6320.32 series) or to the activity designated by the Commandant of the Marine Corps for Marine Corps members. The activity receiving the Health Record shall continue maintenance thereof until disposition is accomplished.

(3) Upon return of a patient to duty where the Health Record is retained by the custodial activity, a summary of the hospitalization shall be entered on SF 600 or the custodial activity shall request an SF 502, Narrative Summary, for filing in the Health Record.

16-24. Hospitalization at Non-Federal Medical Facilities

(1) When a member is admitted directly to a non-Federal medical facility for treatment involving brief periods of hospitalization, the Health Record shall be retained by the activity having custody. However, if it is apparent that the period of hospitalization will exceed 48 hours or the cognizant activity is a vessel or unit scheduled for deployment, the Health Record shall be forwarded to the cognizant office of medical affairs (see BUMEDINST 6320.32 series) or to the activity designated by the Commandant of the Marine Corps for Marine Corps members. The activity receiving the Health Record shall continue maintenance thereof until disposition is accomplished. Upon return of the patient to duty in those instances in which the Health Record was retained by the parent activity, a summary of the hospitalization shall be entered on SF 600.

16-25. Admission to Hospital of Foreign Nation

(1) When a member is hospitalized at a medical facility of a foreign nation, an entry of this fact shall be made in the Health Record; however, this entry shall not be designated as an official transfer to that hospital. The Health Record shall be retained on board and continued until the patient either returns to duty or is transferred to another U.S. Navy vessel or U.S. military activity. Upon departure of the vessel from the port, the Health Record will be delivered to the commanding officer for inclusion in the member's service record for forwarding to the nearest U.S. embassy or consul. The embassy or consul shall be furnished with a complete history of the reason for hospitalization and shall be requested to cooperate with the surgeon in charge of the hospital with a view toward having the member properly cared for. Upon the member's recovery, the embassy or consul shall arrange for the member's transportation, with records, to the nearest naval activity.

16-26. Reserve Members Not on Active Duty

(1) Health Records of members of the Naval Reserve, Fleet Reserve, Marine Corps Reserve, and Fleet Marine Corps Reserve NOT ON active duty shall be maintained as follows:

(a) *Naval reservists assigned to a drilling unit of the Naval Reserve*—by the activity supporting the unit to which the reservist is assigned.

(b) *Naval reservists in Training Category E and all other participating naval reservists who are reported via Commandant's RUPPERTS*—by the cognizant area coordinator designated by CNO. (The area coordinator may delegate maintenance responsibility to an appropriate training center or activity.)

(c) *Other naval reservists and fleet reservists*—by the Naval Reserve Personnel Center, 4400 Dauphine St., New Orleans, LA 70149.

(d) *Class II, Marine Corps reservists*—by the Organized Marine Corps Reserve unit to which assigned.

(e) *Fleet Marine Corps Reserve members*—by Marine Corps Reserve Support Center, 10950 El Monte, Overland Park, KS 66211.

(f) *Class III, Marine Corps reservists*—by Marine Corps Reserve Support Center, 10950 El Monte, Overland Park, KS 66211.

(2) For inactive reservists who desire to affiliate with Ready Reserve units, the Health Record shall be maintained as follows:

(a) *Navy*—by the Naval Reserve Personnel Center, 4400 Dauphine St., New Orleans, LA 70149.

(b) *Marine Corps*—by Marine Corps Reserve Support Center, 10950 El Monte, Overland Park, KS 66211.

16-27. Unidentified, Lost, Damaged, or Destroyed Health Records

(1) When a Health Record is lost or destroyed, the cognizant custodian shall cause a replacement Health Record to be opened. The designation REPLACEMENT shall be prominently entered on the jacket and on all forms replaced. A synopsis of the circumstances requiring a replacement and date accomplished shall be set forth as a note on the replacement SF 600. If the missing record is subsequently recovered, the additional information or entries contained in the replacement record shall be inserted in the original record. Since COMNAV MEDCOM does not maintain a copy of current Health Records, it is unable to furnish replacements for original records either lost or destroyed.

(2) Health Record forms shall be duplicated whenever they approach a state of illegibility or deterioration which may possibly endanger their future use or value as permanent records. The duplicate forms shall be a like reproduction of the

original insofar as possible. Particular attention to detail shall be employed in the actual transcription. When the entire contents of the Health Record are duplicated, the designation DUPLICATE shall be prominently entered on the jacket and on all duplicated forms. When only a part of the Health Record is duplicated, the duplicated forms shall be individually identified as DUPLICATE. The circumstances necessitating duplication and the date accomplished shall be set forth as a note on SF 600. All forms replaced by a duplicate shall be placed in a plain envelope for protection and preservation and made a permanent part of the Health Record. On the front of the envelope, record the identifying data required by article 16-29(2) and list the original records contained therein. Mark the envelope "Original Health Records—Permanent" and file as the bottommost form on the right side of the Health Record jacket.

(3) If a Health Record or Health Record forms are held of a member who has transferred to a new duty station, the new duty station address shall be ascertained from NAVMED 6150/7, Health Record Receipt, File Chargeout, and Disposition Record, and the record/forms forwarded. (See arts. 16-4A(1)(c)(6) and 16-18(4).) In those instances when the subsequent duty station is not documented on NAVMED 6150/7, the following alternate steps shall be taken:

(a) *Navy Members.*—

(1) Contact the personnel support detachment (PSD) for assistance. Many detachments have access to worldwide locators.

(2) If the PSD cannot provide required assistance, send an alphabetical listing of the records (not the records) held at your activity to the Naval Military Personnel Command, NMPC-036. Attn: Navy Worldwide Locator Service, Washington, DC 20370. The alphabetical listing should include member's name, social security number, and grade or rate. The letter of transmittal should request a return notification of actual location of records or present duty station of each member listed.

(3) When the Worldwide Locator Service cannot provide required assistance, forward a listing (not the records) to the Naval Reserve Personnel Center, Code 40M, 4400 Dauphine Street, New Orleans, LA 70149. The alphabetical listing should include member's name, social security number, and grade or rate. The letter of transmittal should request a return notification of the actual location of records or present duty station of each member listed.

(b) *Marine Corps Members.*—

(1) Contact the unit administrative office or the base worldwide locator for assistance. Each Marine Corps base has a worldwide locator.

(2) If the unit administrative office cannot provide required assistance, send an alphabetical listing of the records (not the records) held at your

activity to the Commandant of the Marine Corps, Code MMRB 10, Headquarters, United States Marine Corps, Washington, DC 20380. The alphabetical listing should include member's name, social security number, and grade. The letter of transmittal should request a return notification of the actual location of records or the present duty station of each member listed.

(3) When Headquarters, United States Marine Corps cannot provide required assistance, forward a listing (not the records) to the Marine Corps Reserve Support Center, Attn: MEDMOD, 10950 El Monte, Overland Park, KS 66211. The alphabetical listing should include member's name, social security number, and grade. The letter of transmittal should request a return notification of the actual location of records or the present duty station of each member listed.

(c) *Navy and Marine Corps Members.*—If these efforts fail to determine a member's duty station or location of records, forward a listing (not the records) to the Navy Medical Records Liaison Officer (NMRLO), National Personnel Records Center, Military Personnel Records, GSA, 9700 Page Boulevard, St. Louis, MO 63132. The NMRLO will advise you whether any of the listed members have completed their service obligation and if their records have been retired at the Center.

(4) When the location of a member's record is determined, prepare a letter of transmittal enclosing the records or bits and pieces of a record and stating the reason the enclosures were not previously included in the record. If the above measures fail to determine appropriate disposition, records or bits and pieces of records shall be returned to the sender for disposition.



Section V. DD FORM 722, HEALTH RECORD JACKET, AND DD FORM 722-1, DENTAL FOLDER

	Article
General	16-28
Preparation	16-29

16-28. General

(1) A new Health Record Jacket (DD 722) or Dental Folder (DD 722-1), in addition to being prepared upon the entry or reentry of a member into the naval service, shall also be prepared when either the existing jacket or folder has been damaged or, because of deterioration, is approaching the point of illegibility. The old jacket or folder shall be destroyed following replacement. (See art. 6-109 for additional data on the DD 722-1.)

16-29. Preparation

(1) The data noted below shall be entered on the lip of the DD 722. The same data, less blood group and Rh type, shall be entered on the lip of the DD 722-1.

(2) Enter full name (last, first, and middle name, in that order). The name shall be followed by the member's social security number, date of birth, and, only on the DD 722, the blood group and Rh type. If there is no middle name, the entry "n" or "NMN" shall *not* be used. If the member uses initials instead of first or middle names, show this by enclosing the initials in quotation marks; e.g., "J" "C". Indicate JR, SR, III, etc., following the member's middle name, or in the absence of a middle name the first name.

(3) The information may be typed, printed, stamped, or attached by gum label or a combination thereof.

(4) The following are examples of appropriate formats:

JONES, HARRY WILL 111-22-3333 29 MAR 1923 O NEG

JONES, Harry William, Jr.
111-22-3333 29 MAR 23 O Neg

JONES, Harriet Marie 111-22-3334 23 MAR 29 Blood Group B Neg

JONES, "T" "X" III
111-22-3335 1 APR 30 O Neg

Section VII. STANDARD FORM 88, REPORT OF MEDICAL EXAMINATION

	Article
General	16-37
Preparation	16-38
Identifying Body Marks	16-39

16-37. General

(1) SF 88, Report of Medical Examination, is to be prepared whenever a complete report of physical examination is accomplished.

(2) Entries on the SF 88 shall not be pretyped, preprinted, or otherwise entered or reproduced in advance. Past experience has shown that such advance entries often resulted in the inclusion of observations or judgments not actually made by the medical examiner, or in failure to incorporate data noted during the course of the examination.

16-38. Preparation

(1) *Requirements.*—Specific requirements for submittal and disposition of the forms in the major categories are tabulated in article 15-90.

(2) *Details of Entries.*—

(a) *Item 1, Last Name—First Name—Middle Name.*—The surname shall be recorded in capitals. The Christian name(s) shall be recorded in full without abbreviation. If the individual's first or middle name consists only of an initial, each initial shall be enclosed with quotation marks. Designations such as "JR" or "II" shall appear after the middle name or initial. In the absence of a middle name or initial and if "JR" or "II" is applicable the "JR" or "II" shall be entered in the space.

(b) *Item 2, Grade and Component or Position.*—Use official abbreviation of current grade or rate, branch of service, class and status; i.e., Regular, Reserve, or retired and if active or inactive. For officers also show the assigned designator or MOS.

(c) *Item 3, Identification.*—Enter the social security number.

(d) *Item 4, Home Address.*—Enter the official home address as reported in the current service record or enlistment contract.

(e) *Item 5, Purpose of Examination.*—Use phraseology similar to that contained in the second column of article 15-90. Avoid use of nonstandard abbreviations. When necessary continue under "Notes."

(f) *Item 6, Date of Examination.*—Actual date of examination is to be written in the format of 5 JAN 59 or 5 JAN 1959. Abbreviations for months shall consist of the first three letters of the month only.

(g) *Item 7, Sex.*—Spell out; do not abbreviate.

(h) *Item 8, Race.*—Entries shall be confined to one of the following five classifications:

(1) Caucasian (Cauc.). (Puerto Rican (White) shall be recorded as Caucasian.)

(2) Negroid (Neg.). (Puerto Rican (Negro) shall be recorded as Negroid.)

(3) Mongolian (Mong.). (Chinese, Japanese, Korean, and Eskimo shall be recorded as Mongolian.)

(4) Indian (Ind.). (American.)

(5) Malayan (Mal.). (Filipino, Samoan, Chamorro, and Hawaiian shall be recorded as Malayan.)

(i) *Item 9, Total Years Government Service.*—In "Military" block enter the time (expressed in years and months) served in any branch of the U.S. military services, to include both active and inactive service; i.e., USAF 3y 3m, USA 3y 3m, USN & USNR 3y 3m. The "Civilian" block shall ordinarily be left blank.

(j) *Item 10, Agency.*—Leave blank for military personnel.

(k) *Item 11, Organization Unit.*—List name of ship or station to which examinee is attached.

(l) *Item 12, Date of Birth.*—Use format of 6 JUN 40 or 6 JUNE 1940.

(m) *Item 13, Place of Birth.*—Enter city, town, or village; and state. If rural, the name of the county may be used. For foreign born, enter the name of country as known at the time of the individual's birth.

(n) *Item 14, Name, Relationship, and Address of Next of Kin.*—List as reported on the member's current Record of Emergency Data, DD 93.

(o) *Item 15, Examining Facility or Examiner, and Address.*—Record official title and location of the activity or office at which the examination was conducted.

(p) *Item 16, Other Information.*—Religion shall be shown in this block as "P" for Protestant, "C" for Catholic, or "H" for Hebrew. The specific denomination of any of the religions (i.e., Baptist, Lutheran, Methodist, Presbyterian), although desirable, is not required, unless requested by the individual. The religion of persons belonging to other religious faiths shall be fully recorded. If a person does not desire to state a religious preference, enter "none stated". If the person does not have a religious preference, enter "no preference". The word "None" is to be used only when the person claims no religious convictions.

(q) *Item 17, Rating or Specialty.*—Use only for designated aviation personnel and for qualified

submarine and diving personnel. For aviation personnel enter type (for example, NA for Naval Aviator, and NFO for Naval Flight Officer). Following type, enter date of designation as naval aviator or class 2 aviation personnel and anthropometric size code. In block "Time in This Capacity" enter total flight hours. Hours of flying time in last 6 months shall be entered in the appropriate block. For submarine and diving personnel, record respective specialty for which qualified: i.e., "Qualified for Submarine Duty" or "Qualified Diver 1st class."

(r) *Items 18—43 (Inclusive), Clinical Evaluation.*—Check each item in appropriate column. Enter "NE" for any items not evaluated. The medical examiner shall describe each abnormality in detail in this space designated "Notes" on the face of the form; if additional space is required, continue in item 73. Marks and scars indicated in block 39 shall also be shown under "Notes" using descriptive designations as outlined in article 16—39.

(s) *Item 44, Dental.*—If a dental officer is not available, the examinee's dental qualifications, other than of candidates of the U.S. Naval Academy, shall be determined by the medical officer and entered under "Remarks" of item 44 with the statement, "Examination not performed by dental officer." Also under "Remarks" show Type of Examination (see art. 6—100) and Dental Classification (see art. 6—100).

(t) *Items 45—50, Laboratory Findings.*—Report findings of laboratory tests or other examinations required incident to a physical examination, insert in item 47 the date of any serological examinations of the blood, and in 49 enter Rh factor and record blood group by use of international classification letters O, A, B, or AB. In the absence of proper facilities to accomplish any of the foregoing examinations or any other portion of the physical examination, a notation to this effect shall be entered in block 73 of the form, followed by the stipulation that the examination(s) shall be completed at the member's first active/training duty station where adequate medical facilities are available. The result of any special tests conducted incident to the physical examination shall be continued in item 73 or on SF 507 if necessary. Specify any tests which are listed but not required and those which are required but not accomplished.

(u) *Item 51, Height.*—Record in inches to nearest one-half inch (1.27 cm), except for aviation physical examinations where it shall be to the nearest one-tenth inch (0.254 cm). Include height in centimeters in parenthesis (multiply inches by 2.54). For aviation physical examinations when anthropometric measurements are required, the results should be submitted on the appropriate worksheet as shown in BUMEDINST 3710.1 or they may be recorded in the margin above block 51 as shown in article 16—74, illustration 1C.

(v) *Item 52, Weight.*—Record in numerals to the nearest pound. (Show kilograms in parentheses. Multiply pounds by 0.45.)

(w) *Item 53, Color Hair.*—The color of the hair shall be entered as flaxen, sandy (yellow—red), auburn (red—brown), brown (light, medium, or dark), black, gray, etc. Race classification shall not be used in connection with color description.

(x) *Item 54, Color Eyes.*—In entering color do not use race classification with color description.

(y) *Item 55, Build.*—Indicate by an 'X' in the appropriate block.

(z) *Item 56, Temperature.*—Record degree in Fahrenheit. (Show celsius in parentheses. Subtract 32 from Fahrenheit temperature; multiply result by 0.56.)

(aa) *Items 57—72, Physical Evaluation.*—To provide uniformity and completeness in the recording of information in these items, reference shall be made to chapter 15 or current directives which prescribe the nature and scope of each physical examination and the application of these items to the particular program and rate or grade involved.

(bb) *Item 73, Notes and Significant or Interval History.*—

(1) Indicate any pertinent medical history; include resume for any condition which is likely to recur or cause more than minimal loss of time from duty. An accurate and comprehensive history may be of great value in pointing to future diagnosis. Also include any information acquired incident to special referral or consultation. On all aviation post-hospitalization physical examinations, give a resume of hospitalization and include name of hospital, date of admission and discharge, diagnosis, and a brief summary of treatment; also, prognosis if not completely recovered.

(2) For all aviation physical examinations, a space 4 inches (10 cm) on the right side shall be reserved for the required COMNAVMECOM endorsement (see art. 16—74, illustrations 1C and 1E).

(cc) *Item 74, Summary of Defects and Diagnoses.*—

(1) All defects and diagnoses found must be recorded and described adequately. The defects shall be listed in the summary in the order of their importance. The irremediable, disqualifying, and permanent defects shall be listed first. All minor defects noted shall be recorded to protect the Government in the event of future claims for disability compensation. When an individual has a disease or other physical condition that, although not disqualifying, requires medical treatment, the nature of the condition and the need for treatment shall be clearly stated.

(2) For all aviation physical examinations, a space 4 inches (10 cm) on the right side shall be reserved for the required COMNAVMECOM endorsement (see art. 16—74, illustrations 1C and 1E).

(dd) *Item 75, Recommendations.*—Indicate any medical or dental recommendations. Specify the particular type of any further medical or dental specialist examination indicated (continue in item 73 or SF 507 if necessary).

(ee) *Item 76, Physical Profile.*—There is no requirement for the physical profiling of Navy and Marine Corps personnel except for the initial physical profiling accomplished at Armed Forces Entrance and Examining Stations (AFEES).

(ff) *Item 77, Examinee's Qualification.*—Regardless of the purpose of the examination, a determination about an examinee's physical ability to perform active duty at sea, and/or on foreign service, or in the field, as appropriate, and such other information as may be required by current instructions shall be stated.

(gg) *Item 78, Disqualifying Defects.*—Indicate item number only.

(hh) *Items 79-82, Signature.*—The name, grade, branch of military service, and status of each medical and dental examiner shall be typewritten, printed, or stamped in the left section. Each examiner shall sign with blue-black or black pen in the right section. Facsimile signature stamps shall not be used. When attachment sheets are used as a supplement or continuation to the report, they shall be serially numbered (both sides); however, only the actual number of attached sheets shall be indicated in the bottom right block of SF 88.

16-39. Identifying Body Marks

(1) The medical examiner shall make a careful inspection of the body, front and rear, on each side of

the median line separately, commencing with the scalp and ending at the foot, and record under the "Notes" section on the front of the SF 88 all body marks, tattoos, and scars of value for purposes of identification. If no marks or scars are found, this fact shall be stated.

(2) The sizes of scars, moles, warts, birthmarks, etc., shall be indicated in centimeters (i.e., 1.25 cm), except for pinhead moles for which the abbreviation "p.m." shall be used. Pinhead moles are those presenting a diameter of less than one-eighth of an inch (16 mm). When recording the location of a tattoo mark, a narrative description of the design shall be included. Tattoo transcriptions of words or initials shall be recorded in capital letters. The size of a tattoo need be described only regarding its general dimensions. A statement relative to color or pigment is not required. Amputations and losses of parts of fingers and toes should be noted, showing the number of the particular digit injured and the extent or level of absence.

(3) The following are authorized abbreviations for the description or conditions indicated: amp.—amputation, f.—flat, fl.—fleshy, h.—hairy, lr.—linear, m.—moles, p.—pitted, p.m.—pinhead mole, r.—raised, s.—scar or smooth, var.—varicose veins or varicocele, va.—vaccination scar, w.—wart. Combinations of the above abbreviations are permissible. Size shall be indicated in metric measurements. Abbreviations shall not be used in description of tattoo marks since they are likely to be mistaken as signifying tattooed letters on the individual's body.

Section VIII. STANDARD FORM 93, REPORT OF MEDICAL HISTORY

	Article
General	16-41
Preparation	16-42

16-41. General

(1) The purpose of the SF 93, Report of Medical History, is to provide a complete personal medical history report and a source of information supplemental to that reported on the SF 88. Since the Health Record is not prepared until the person enters the service, the SF 93 provides a current, concise, and comprehensive record of a member's personal medical history, prior to entrance into the Naval service and any subsequent change in status.

16-42. Preparation

(1) The personal information items of the SF 93, items 1 through 6, shall be completed (ink, indelible

pencil, or typewritten) in accordance with the instructions applicable to corresponding items of the SF 88 (art. 16-38(2)). (See also art. 16-74, illustrations 2 and 2A.)

(2) Every assistance shall be afforded to the examinee to assure full and clear comprehension of the terminology appearing in items 9 through 24, thereby enabling the examinee to provide a concise and accurate history.

(3) Item 25 (Physician's summary) shall be prepared and signed by the medical examiner and in no instance shall this item be left blank.

(4) Preparation of carbon copies is authorized subject to the requirement that all copies bear the signature of the examinee and the medical examiner and that complete legibility is maintained.

Section IX. STANDARD FORM 600, CHRONOLOGICAL RECORD OF MEDICAL CARE

	Article
General	16-44
Sick Call Treatment Entries	16-45
Binnacle List and Sicklist Entries	16-46
Blood Grouping and Typing Record	16-47
Other Entries	16-48

16-44. General

(1) The SF 600, Chronological Record of Medical Care, provides a current, concise, and comprehensive record of a member's military medical history. Properly maintained, the SF 600 should facilitate the evaluation of a patient's physical condition; greatly reduce correspondence to obtain medical records; eliminate unnecessary repetition of expensive diagnostic procedures; and serve as an invaluable permanent record of medical evaluation and treatment received.

(2) Each entry shall be dated and the name and address of the treatment activity shall precede the entry. Entries shall be typewritten when practicable. Sick call entries may be handwritten in black or blue-black pen. Each entry shall be signed by the responsible medical officer or Medical Department representative. (See art. 16-18(5).) When a new SF 600 is initiated, the identification block shall be completed with the name (last, first, middle initial), sex (M or F), date of birth (not year), component (active duty, Reserve, or retired), service (USN, USMC, etc.), SSN (followed by the designator code or MOS for officers), and the member's grade/rate and organization at the time the form is completed. (See art. 16-74, illustrations 3, 3A, and 3B.)

(3) The SF 600 shall be continuous and include the following information as indicated: complaints, duration of illness or injury, physical findings, clinical course, results of any laboratory or special examinations, treatment (including operations), physical fitness at time of disposition, and disposition.

16-45. Sick Call Treatment Entries

(1) Whenever a member is evaluated at sick call, an entry shall be made on the SF 600 reflecting the complaints or conditions presented, pertinent history, any treatment rendered, and disposition. In the event of injury or poisoning, the duty status of the member at the time of occurrence, and the circumstances of occurrence shall be recorded in accordance with the guidelines contained in BUMEDINST 6300.3 series (Inpatient Data System).

(2) In those instances where a member of the naval service incurs an injury which might result in a permanent disability or which results in physical inability to perform duty for a period exceeding 24 hours, an entry shall be made concerning line of duty and misconduct (see chap. VIII, JAG Manual). Such entry shall include specific facts concerning time, place, names of persons involved, and circumstances surrounding the injury.

(3) Whenever outpatient treatment is furnished to a member whose health record is not available, the information shall be reported on a DD 689, Individual Sick Slip (see sec. XVII concerning use and preparation of this form). When a DD 689 is received at the treatment facility that normally provides care for the member, the information contained therein shall be transcribed to the member's SF 600. This entry shall include name and status of the individual who rendered the treatment, and the signature and grade/rate of the person responsible for the transcription.

16-46. Binnacle List and Sicklist Entries

(1) When a member's name is placed on the binnacle list for treatment, an entry shall be made on the SF 600 showing date, diagnosis, and a resume of treatment.

(2) Upon admission of an active duty member to the sicklist, the Medical Department representative shall enter information on the SF 600 or SF 502 concerning the nature of the disease, illness, or injury, pertinent history or circumstances of incurrence, treatment rendered, and disposition. An entry shall also be made concerning line of duty and misconduct determinations (see chap. VIII, JAG Manual).

(a) Whenever the cause of admission results in the submission of an injury report or investigative report to JAG in accordance with the guidelines in the JAG MANUAL, and entry should be made, if practicable, on the SF 600 reflecting the final determination of JAG.

(b) For any injuries not reported to JAG by an injury report or investigative report, the Health Record entry shall contain facts as specific as possible concerning time, place, names of persons involved, and circumstances surrounding the injury.

16-47. Blood Grouping and Typing Record

(1) Determination of blood group and Rh type on recruits at naval training centers and Marine Corps recruit depots shall be accomplished by specified naval hospitals and medical clinics on a semiautomated mechanical system, known as the Automatic Blood Typing AutoAnalyzer. The interpreted machine output shall be affixed to a separate SF 600, which shall be identified as "Blood Grouping and Typing Record." When the "Blood Grouping and Typing Record" is incorporated in a Health Record, no additional entry as to blood group and Rh type is required on the SF 601, Immunization Record, for that Health Record.

(2) The "Blood Grouping and Typing Record," SF 600, shall be prepared with column headings to indicate what each respective column on the machine output represents. Persons knowledgeable in the technique of automated blood grouping and typing will be able to verify the interpretation of the results at any time, for administrative purposes, merely by reading the machine output. The specific interpretive information provided on the "Blood Grouping and Typing Record" shall identify the individual by the appropriate ABO group and Rh type (positive or negative). Matching the sequential number on the machine output with the processing or blood number near the bottom of the page is verification that the correct machine output has been affixed to the correct SF 600, "Blood Grouping and Typing Record."

(3) The "Blood Grouping and Typing Record" shall contain a syphilis screening test and possibly other screening tests for the presence of certain disease conditions. These will be identifiable by respective column headings determined at the processing hospital. In addition, the machine output may indicate the presence of abnormal blood antibodies.

(4) The "Remarks" section on the form shall contain an entry when there is agglutination in channel 8 (O cells) of the machine output.

(5) This SF 600 shall constitute the source document for blood group and type entries required elsewhere in the Health Record (i.e., DD Form 722, SF 88, etc.) or on official documents.

(6) In the event of machine unavailability, the required determination of ABO group and Rh type shall be performed manually and entered in the Health Record as appropriate.

16-48. Other Entries

(1) When a member of the naval service is

injured or contracts a disease while on leave, or when for any other reason the facts concerning an injury or sickness have not been entered in the individual's Health Record, the medical officer or Medical Department representative having custody of the record shall ascertain the facts and make the necessary entries.

(2) When, for any reason, an enlisted member undergoing treatment at a naval hospital is held in the custody of civil authorities, every effort shall be made to ascertain the length of time the member will be held pending disposition. Upon receipt of information that the individual will be retained in the custody of civil authorities for a period in excess of 7 days, the member shall be officially transferred to an intermediate naval activity. This activity should be the nearest naval command which has facilities to receive and process personnel discharged from treatment. Complete information regarding the incident and the need for further hospitalization shall be entered in the Service Record for naval personnel, and the Service Record Book for Marine Corps personnel. A letter setting forth all the facts concerning the incident shall be forwarded to NAVMILPERSCOM or the CMC, as appropriate, and to the intermediate activity to which the transfer is made. The current SF 600 shall be closed as to D (Discharged From Sicklist). This procedure prevents charging the health of the Navy with the sick days not actually incurred as a result of service conditions.

(3) Dental treatments shall be recorded on SF 600 whenever the conditions set forth in article 6-119 apply.

(4) Results of laboratory examinations made on personnel exposed to radiological hazards shall be entered on SF 600, listing any abnormalities and indicating action taken.

(5) When a patient is transferred and radiographs are transferred with them, a notation to that effect shall be entered on SF 600 or SF 502, as appropriate.

(6) Any hypersensitivity to drugs or chemicals known to exist shall be documented on a separate SF 600 which shall be annotated at the bottom of the form with the words "SPECIAL-HYPERSENSITIVITY." (See art. 16-4A(1) for filing instructions.) Hypersensitivities shall also be recorded on the SF 601, SF 603, and DD 722-1. (See arts. 16-50 (3) and 6-112(4).)

(7) When an individual is assigned to duty involving exposure to high intensity noise, a reference audiogram shall be conducted and the results recorded on DD 2215.

Section X. STANDARD FORM 601, IMMUNIZATION RECORD

	Article
General	16-49
Entries	16-50
International Travel	16-51

16-49. General

(1) The purpose of the SF 601 is to record information which pertains to prophylactic immunizations; sensitivity tests; reactions to transfusions, drugs, sera, food, and allergies; and blood typing. The recordings shall be continued on the current record until additional space is required under any single category. In such instances, a new SF 601 shall be inserted and retained with the old SF 601's. Concurrently, a thorough verification of the entries shall be made and all immunizations brought up to date. Replacement of the current SF 601 is not required because of a change in grade, rating, or status of the member concerned. Under no circumstances shall the SF 601 be maintained separately from the Health Record.

16-50. Entries

(1) The name of the medical officer or Medical Department representative administering the immunization or test, or determining the nature of the sensitivity reaction, shall be typed or stamped on the SF 601. Signatures on SF 601 are not required.

(2) The medical officer or the Medical Department representative administering the immunizations shall be responsible for the completion of all entries in the appropriate section of SF 601, including required entries on reactions.

(3) Information concerning a determined hypersensitivity to a drug or chemical shall be indicated under "Remarks and Recommendations." Appropriate entries (such as HYPERSENSITIVE TO ASPIRIN, HYPERSENSITIVE TO PROCAINE) shall be typed in capitals. This is in addition to a similar entry required on SF 603 and the SF 600, SPECIAL-HYPERSENSITIVITY, which is retained in the Health Record.

16-51. International Travel

(1) All military and nonmilitary personnel performing international travel under the cognizance of the Department of the Navy shall be immunized in accordance with BUMED Instruction 6230 series and current edition of the publication NAVMED P-5052-15A; and shall have in their possession a properly completed and authenticated PHS Form 731, International Certificates of Vaccination.

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Section XI. STANDARD FORM 602, SYPHILIS RECORD

	Article
General	16-52
Explanation to Patient	16-53

16-52. General

(1) The SF 602, Syphilis Record, shall be prepared upon the occurrence of a syphilitic infection, including any complication or sequela thereof. This record shall be retained as a permanent component part of the member's Health Record. The above procedure is applicable regardless of whether or not more than one SF 602 is required during the member's term of service. An entry shall be made covering each course of treatment given and each luec examination or test conducted.

16-53. Explanation to Patient

(1) The medical officer shall carefully and thoroughly explain to the patient the nature of the infection and the reasons why treatment, prolonged observation, and the repeated performance of certain prescribed tests are necessary. The patient shall then be requested to sign the statement in section II of SF 602.

Section XII. STANDARD FORM 603, DENTAL

	Article
General	16-54

16-54. General

(1) The SF 603, Dental, shall be prepared in accordance with the detailed instructions in articles 6-107 through 118.

(2) Article 6-118 contains illustrations of markings on dental charts.

Section XIII. NAVMED 6150/4, ABSTRACT OF SERVICE AND MEDICAL HISTORY

	Article
Purpose.	16-55
Entries.	16-56
Disposition.	16-57

16-55. Purpose

(1) The NAVMED 6150/4, Abstract of Service and Medical History, provides (a) chronological history of the ships and stations to which a member is assigned for duty and treatment and (b) an abstract of medical history for each admission to the sicklist.

16-56. Entries

(1) *SHIP OR STATION Column.*—Enter the name of the ship or activity to which attached for duty or treatment.

(2) *DIAGNOSIS, DIAGNOSIS NO., AND REMARKS Column.*—Enter the diagnosis title and number each time final disposition from the sicklist is made.

(3) *DATE Column.*—Indicate in the FROM and TO subcolumns all dates of reporting and detachment for duty, or dates of admission and discharge from the sicklist. Upon transfer for temporary duty, an entry shall be made only if the Health Record is to accompany the individual to the place of temporary duty.

16-57. Disposition

(1) The NAVMED 6150/4 shall be retained as a permanent component part of the Health Record. The entry upon closure shall indicate date, title of servicing activity, and explanatory circumstances as may be indicated.

1. The first part of the report is a summary of the work done during the year.

2. The second part is a detailed account of the work done during the year.

3. The third part is a summary of the work done during the year.

4. The fourth part is a summary of the work done during the year.

5. The fifth part is a summary of the work done during the year.

6. The sixth part is a summary of the work done during the year.

7. The seventh part is a summary of the work done during the year.

8. The eighth part is a summary of the work done during the year.

9. The ninth part is a summary of the work done during the year.

10. The tenth part is a summary of the work done during the year.

Section XIV. NAVMED 6150/2, SPECIAL DUTY MEDICAL ABSTRACT

	Article
General	16-58
Entries	16-59
Disposition	16-60

16-58. General

(1) The purpose of the NAVMED 6150/2, Special Duty Medical Abstract, is to provide a record of physical qualifications, special training, and periodic examinations of members designated for performance of special duty, such as aviation, submarine, and diving. The object of the special duty examination, and the instructions incident thereto, is to select only those individuals who are physically and mentally qualified for such special duty, and to remove from such status those members who may become temporarily or permanently unfit for such duty because of physical or mental defects. Also, in this connection, special money disbursements are often based upon the determination of a member's physical and mental qualifications or continued requalification for performance of a special duty. Therefore, accuracy and content of information are essential in the reporting of information applicable to these categories.

16-59. Entries

(1) The entries shall be recorded upon completion of each physical examination and completion

of designated special training. When a previously qualified member is suspended from special duty for physical reasons, the period of suspension and reason therefor shall be entered on the NAVMED 6150/2.

(2) The scope of the physical examination and technical training prescribed for these special categories often differs from the general service requirements; therefore, entries reporting results which pertain to these particular examinations or training involved shall be approved only by medical officers or specially designated medical service corps officers who are familiar with their scope and nature (i.e., aerospace physiologists for aerospace physiology training).

16-60. Disposition

(1) The NAVMED 6150/2 shall be retained as a permanent part of the Health Record.

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Section XV. DD FORM 1141, RECORD OF OCCUPATIONAL EXPOSURE TO IONIZING RADIATION

	Article
General	16-81
Method of Recording	16-82
Disposition	16-83

16-81. General

(1) The DD Form 1141, Record of Occupational Exposure to Ionizing Radiation, shall be initiated when military personnel are first exposed to ionizing radiation. (Exception: Ionizing radiation incurred by patients undergoing diagnostic procedures and treatment.)

16-82. Method of Recording

(1) Instructions for preparation of DD Form 1141 are contained on the back of the form. Fur-

ther instructions concerning the applicability and use of the form and the source of necessary information are contained in the NAVMED P-5055, Radiation Health Protection Manual.

16-83. Disposition

(1) The DD 1141 shall be retained as a permanent part of the Health Record.

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE
FOR THE YEAR 1890

1890

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The following is a list of the lands which have been surveyed and patented by the General Land Office during the year 1890:

1. The following lands were surveyed and patented by the General Land Office during the year 1890:

The following is a list of the lands which have been surveyed and patented by the General Land Office during the year 1890:

Section XVI. ADJUNCT HEALTH RECORD FORMS AND REPORTS

	Article
General	16-64
Standard Form 502, Narrative Summary	16-65
Standard Form 539, Abbreviated Medical Record	16-66
Standard Form 513, Consultation Sheet	16-67
Medical Board Report (NAVMED 6100/1)	16-68
DD Form 771, Eyewear Prescription	16-69

16-64. General

(1) This section provides instructions for the use of certain forms in the Health Record in lieu of transcribing data therefrom to the SF 600, Chronological Record of Medical Care.

16-65. Standard Form 502, Narrative Summary

(1) The purpose of the SF 502 is to summarize pertinent clinical data relative to treatment received during periods of hospitalization. For all members (officer and enlisted), the original (typewritten) of the SF 502 shall be placed in the Health Record in lieu of transcribing the information therefrom to the SF 600. When appropriate, a copy of the SF 502 shall be placed in the Dental Folder.

16-66. Standard Form 539, Abbreviated Medical Record

(1) A copy of Standard Form 539, when used for active duty personnel in uncomplicated inpatient care of brief duration (less than a 48-hour period of hospitalization), and when SF 502, Narrative Summary, is not otherwise required, may be filed in the Health Record. However, the information entered on SF 539 must be legible, and must provide adequate documentation concerning the origin, nature, conduct status, and aggravation by service, if any, of the condition requiring hospitalization.

16-67. Standard Form 513, Consultation Sheet

(1) When a report of consultation on an outpatient is recorded on SF 513, it may be

incorporated directly in the Health Record, thereby eliminating transcription to the SF 600.

(2) The SF 513 may be used by dental officers requesting a medical consultation on a dental patient. (See art. 6-120.)

16-68. Medical Board Report (NAVMED 6100/1)

(1) Whenever a member of the naval service is reported on by a medical board, a legible copy of the report may be placed in the Health Record in lieu of transcribing the clinical data to the SF 600. A notation shall also be made on the current SF 600 to indicate that the clinical data is contained in the copy of the medical board report which has been incorporated in the Health Record. When the medical board report is forwarded to the Navy Department for review and appropriate disposition, a report of the Departmental action shall be entered on the current SF 600.

16-69. DD Form 771, Eyewear Prescription

(1) The purpose of DD Form 771, Eyewear Prescription, is to order corrective prescription eyewear and to record information required for the ordering of spectacles.

(2) Upon receipt of prescription eyewear from the ophthalmic laboratory, copy 2, DD Form 771 shall be retained in the member's Health Record. The above procedure is applicable for each DD Form 771 that is submitted to the laboratory during the member's term of service.

Section XVII. DD FORM 689, INDIVIDUAL SICK SLIP, AND CROSS MEDICAL SERVICE NOTIFICATION

	Article
General	16-70
Initiation and Completion	16-71
Use for Army and Air Force Personnel	16-72
Use for Naval Personnel	16-73

16-70. General

(1) The DD 689, Individual Sick Slip, is devised for the purpose of cross medical service notification between the armed services. The DD 689 may also be used to exchange information between the medical officer concerned and unit commander within the naval establishment. When a member, following treatment, is unable to return to assigned organization either for duty or reporting purposes, use of the form does not preclude the immediate notification of a member's unit commander by telephone or message, if practicable, and considered necessary.

(2) The DD 689 may be initiated for an individual who has requested and/or received medical treatment of a sick call nature. It serves as an interim document to furnish information from which subsequent entries shall be recorded in the Health Record.

(3) The DD 689 is not a record document and should be disposed of as soon as it accomplishes its primary purpose, except where further use is indicated such as in connection with line-of-duty determination.

16-71. Initiation and Completion

(1) The DD 689 consists of three sections:

(a) *Personal Identification Data.*—This section may be filled in by or for the patient either at the place of duty or at the medical treatment facility, depending upon local arrangements.

(b) *Unit Commander's Section.*—When completed by the individual's commanding officer, any additional information may be entered under "Remarks" which the unit commander feels may aid the medical officer, or any specific request made of the medical facility, or information which may be of value in determining line-of-duty status.

(c) *Medical Officer's Section.*—This section is to be completed by the medical officer or Medical Department representative administering treatment. If it appears that line-of-duty determination will be predicated on a medical opinion, the "line-of-duty" block shall be completed. The disposition of the patient shall be indicated by a check mark in the

appropriate box. An individual excused from duty shall be reported under one of the following dispositions:

- (1) Sick Bay or Clinic.
- (2) Hospital.
- (3) Other (specify).

The ship or station rendering medical treatment shall be indicated under "Remarks" of the Medical Officer's Section. Any additional information or instructions which the medical officer wishes to convey to the patient's unit commander may be entered under "Remarks."

16-72. Use for Army and Air Force Personnel

(1) When an Army or Air Force member reports at a naval facility for medical treatment of a sick-call nature and action is taken to excuse the member from duty, a DD 689 shall be completed by the naval facility, indicating one of the dispositions listed in article 16-71(1)(c), and forwarded to the individual's commanding officer.

16-73. Use for Naval Personnel

(1) *At Army or Air Force Medical Facilities.*—Naval activities will receive DD 689 for members of their units who receive medical treatment of a sick-call nature at Army or Air Force facilities. When circumstances preclude direct cross-servicing of the Health Record, appropriate entries shall be made on the SF 600 from DD 689.

(2) *At Navy Medical Facilities.*—For members in a transient status whose Health Records are not readily available, information relative to sick call visits may be recorded on the DD 689. The DD 689 may likewise be used when a member, attached to a command equipped with several medical facilities, receives treatment at a facility other than that at which the Health Record is normally maintained. In all instances, the DD 689 shall be forwarded to the facility maintaining the member's Health Record and the information recorded therein shall be transcribed to the SF 600 as soon as practicable, and in any event prior to transfer of the member.

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1A. Standard Form 88, Report of Medical Examination (Back).

1B. Standard Form 88, Report of Aviation Candidate Medical Examination (Front).

1C. Standard Form 88, Report of Aviation Candidate Medical Examination (Back).

1D. Standard Form 88, Report of Aviation Annual Medical Examination (Front).

1E. Standard Form 88, Report of Aviation Annual Medical Examination (Back).

2. Standard Form 93, Report of Medical History (Front).

2A. Standard Form 93, Report of Medical History (Back).

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Standard Form 88

Revised 10/75

General Services Administration
Interagency Comm. on Medical Records
FPMR 101-11.806-8

REPORT OF MEDICAL EXAMINATION

1. LAST NAME--FIRST NAME--MIDDLE NAME DOE, John James		2. GRADE AND COMPONENT OR POSITION See art. 16-38(2)(b)		3. IDENTIFICATION NO. See 16-38(2)(c)	
4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code) 444 West Street Bay City, NY 11709		5. PURPOSE OF EXAMINATION See art. 16-38(2)(e)		6. DATE OF EXAMINATION 1 MAY 82	
7. SEX male	8. RACE caucasian	9. TOTAL YEARS GOVERNMENT SERVICE MIUSN 3y3m CIVILIAN		10. AGENCY ---	11. ORGANIZATION UNIT Naval Station, Blank, VA
12. DATE OF BIRTH 3 May 60		13. PLACE OF BIRTH Bay City, NY		14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN Father: John Paul DOE 444 West Street, Bay City, NY 11709	
15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS Naval Station Blank, VA 23708		16. OTHER INFORMATION See art. 16-38(2)(p)			
17. RATING OR SPECIALTY See art. 16-38(2)(q)		TIME IN THIS CAPACITY (Total)		LAST SIX MONTHS See art. 16-38(2)(q)	

CLINICAL EVALUATION		ABNOR MAL	
NOR MAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNOR MAL	
X	18. HEAD, FACE, NECK AND SCALP		
X	19. NOSE		
X	20. SINUSES		
X	21. MOUTH AND THROAT		
X	22. EARS, GENERAL (For A and C, include hearing under items 20 and 21)		
X	23. DRUMS (Perforation)		
X	24. EYES, GENERAL (Visual acuity and refraction under items 19, 20 and 21)		
X	25. OPHTHALMOSCOPIC		
X	26. PUPILS (Equality and reaction)		
X	27. OCULAR MOTILITY (Associated parallel movements, nystagmus)		
X	28. LUNGS AND CHEST (Include breasts)		
X	29. HEART (Thrust, size, rhythm, sounds)		
X	30. VASCULAR SYSTEM (Arteriosclerosis, etc.)		
X	31. ABDOMEN AND VISCERA (Include hernia)		
X	32. ANUS AND RECTUM (Hemorrhoids, fistulas, fissures, if indicated)		
X	33. ENDOCRINE SYSTEM		
X	34. G-U SYSTEM		
X	35. UPPER EXTREMITIES (Strength, range of motion)		
X	36. FEET		
X	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)		
X	38. SPINE, OTHER MUSCULOSKELETAL		
X	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	X	
X	40. SKIN, LYMPHATICS		
X	41. NEUROLOGIC (If equilibrium tests under item 22)		
X	42. PSYCHIATRIC (Specify any personality deviation)		
X	43. PELVIC (Females only) (Check how done) <input type="checkbox"/> VAGINAL <input type="checkbox"/> RECTAL		

NOTES (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

#39 - (identifying body marks) - (See art. 16-39)

ANT: s. 2.54 cm x 1.27 cm lt cheek

POST: w. 1.27 cm d. lt thigh

(Continue in item 73)

44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)																REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES																																																																																																									
<table border="0"> <tr> <td>1</td><td>2</td><td>3</td><td>Restorable teeth</td> <td>1</td><td>2</td><td>3</td><td>Non restorable teeth</td> <td>1</td><td>2</td><td>3</td><td>Missing teeth</td> <td>1</td><td>2</td><td>3</td><td>Replaced by dentures</td> <td>1</td><td>2</td><td>3</td><td>Fixed Partial dentures</td> </tr> <tr> <td>R</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td> <td>9</td><td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td> <td>L</td><td>1</td><td>2</td><td>3</td> </tr> <tr> <td>G</td><td>32</td><td>31</td><td>30</td><td>29</td><td>28</td><td>27</td><td>26</td><td>25</td> <td>24</td><td>23</td><td>22</td><td>21</td><td>20</td><td>19</td><td>18</td><td>17</td> <td>E</td><td>1</td><td>2</td><td>3</td> </tr> <tr> <td>H</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td>F</td><td></td><td></td><td></td> </tr> <tr> <td>T</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td>T</td><td></td><td></td><td></td> </tr> </table>																1	2	3	Restorable teeth	1	2	3	Non restorable teeth	1	2	3	Missing teeth	1	2	3	Replaced by dentures	1	2	3	Fixed Partial dentures	R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L	1	2	3	G	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	E	1	2	3	H																	F				T																	T				Acceptable - Examination not performed by dental officer	
1	2	3	Restorable teeth	1	2	3	Non restorable teeth	1	2	3	Missing teeth	1	2	3	Replaced by dentures	1	2	3	Fixed Partial dentures																																																																																																						
R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L	1	2	3																																																																																																					
G	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	E	1	2	3																																																																																																					
H																	F																																																																																																								
T																	T																																																																																																								

See art. 16-38(2)(t)		LABORATORY FINDINGS		See art. 16-38(2)(s)	
45. URINALYSIS A. SPECIFIC GRAVITY 1.010		46. CHEST X RAY (Place, date, film number and result)		Naval Station, Blank, VA	
B. ALBUMIN neg		D. MICROSCOPIC		1 MAY 82 - 01756 - NEGATIVE	
C. SUGAR neg		NE			
47. SEROLOGY (Specify test used and result)		48. EKG		49. BLOOD TYPE AND RH FACTOR	
1 MAY 82		NE		0-POS	
VDRL - Negative				NE	
				50. OTHER TESTS	

88-118

Illustration 1. Standard Form 88, Report of Medical Examination (Front)

MEASUREMENTS AND OTHER FINDINGS																																							
51. HEIGHT		52. WEIGHT		53. COLOR HAIR		54. COLOR EYES		55. BUILD:		56. TEMPERATURE																													
70 (177.80)		160 (72.00)		Lt. Brown		Brown		<input type="checkbox"/> SLENDER <input checked="" type="checkbox"/> MEDIUM <input type="checkbox"/> HEAVY <input type="checkbox"/> OBESE		98.6 (37.3)																													
57. BLOOD PRESSURE (Arm at heart level)																																							
A. SITTING		B. RECUMBENT		C. STANDING (3 min.)		D. SITTING		E. AFTER EXERCISE		F. 2 MIN. AFTER																													
SYS. 110 DIAS. 76		SYS. 118 DIAS. 74		SYS. 108 DIAS. 74		80		120		84																													
58. PULSE (Arm at heart level)																																							
59. DISTANT VISION																																							
RIGHT 20/		CORR. TO 20/		BY		S.		CX		CORR. TO																													
LEFT 20/		CORR. TO 20/		BY		S.		CX		CORR. TO																													
60. REFRACTION																																							
61. NEAR VISION																																							
62. HETEROPHORIA (Specify distance)																																							
ES* SEE ARTICLE 16-38(2)(aa) CONCERNING COMPLETION OF ITEMS 57 THROUGH 72																																							
63. ACCOMMODATION																																							
RIGHT		LEFT		64. COLOR VISION (Test used and result)				65. DEPTH PERCEPTION (Test used and score)																															
66. FIELD OF VISION		67. NIGHT VISION (Test used and score)				68. RED LENS TEST				69. INTRAOCULAR TENSION																													
70. HEARING																																							
RIGHT WV		/15 SV		/15		71. AUDIOMETER				72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)																													
LEFT WV		/15 SV		/15		<table border="1"> <tr> <td>250</td> <td>500</td> <td>1000</td> <td>2000</td> <td>3000</td> <td>6000</td> <td>8000</td> </tr> <tr> <td>dB</td> <td>dB</td> <td>dB</td> <td>dB</td> <td>dB</td> <td>dB</td> <td>dB</td> </tr> <tr> <td>RIGHT</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>LEFT</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>				250	500	1000	2000	3000	6000	8000	dB	dB	dB	dB	dB	dB	dB	RIGHT							LEFT								
250	500	1000	2000	3000	6000	8000																																	
dB	dB	dB	dB	dB	dB	dB																																	
RIGHT																																							
LEFT																																							
73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY																																							
SEE ARTICLE 16-38(2)(bb) <div style="text-align: right; margin-top: 100px;"> FOR ALL AVIATION PHYSICALS, LEAVE 4 INCHES (10 cm) BLANK SPACE FOR NAVMEDCOM ENDORSEMENT EXTENDING THROUGH ITEM 74. SEE ARTICLE 16-38(2)(bb)(2) & (cc)(2). </div>																																							
74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)																																							
SEE ARTICLE 16-38(2)(cc)																																							
75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)																																							
SEE ARTICLE 16-38(2)(dd)																																							
76. A. PHYSICAL PROFILE																																							
<table border="1"> <tr> <td>P</td> <td>U</td> <td>L</td> <td>H</td> <td>E</td> <td>S</td> </tr> <tr> <td>1</td> <td>1</td> <td>1</td> <td>1</td> <td>1</td> <td>1</td> </tr> </table>												P	U	L	H	E	S	1	1	1	1	1	1																
P	U	L	H	E	S																																		
1	1	1	1	1	1																																		
77. EXAMINEE (Check)																																							
A. <input type="checkbox"/> IS QUALIFIED FOR B. <input type="checkbox"/> IS NOT QUALIFIED FOR																																							
78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER																																							
SEE ARTICLE 16-38(2)(gg)																																							
79. TYPED OR PRINTED NAME OF PHYSICIAN																																							
C. T. BAIRD, LT MC USN																																							
80. TYPED OR PRINTED NAME OF PHYSICIAN																																							
R. M. BRIGHTEN, LT MC USN																																							
81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which)																																							
82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY																																							

Standard Form 88

Revised 10/75

General Services Administration
Interagency Comm. on Medical Records
FPMR 101-11.806-8

REPORT OF MEDICAL EXAMINATION

AVIATION

1. LAST NAME—FIRST NAME—MIDDLE NAME DOE, John Dee		2. GRADE AND COMPONENT OR POSITION Civilian		3. IDENTIFICATION NO. 444-44-4444	
4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code) 1234 Main Street Anywhere, Anystate ZIP		5. PURPOSE OF EXAMINATION (Navy or Marine Corps) Aviation Candidate		6. DATE OF EXAMINATION 19 APR 82	
7. SEX male	8. RACE Cauc., Negroid, etc.	9. TOTAL YEARS GOVERNMENT SERVICE LEAVE BLANK	10. AGENCY LEAVE BLANK	11. ORGANIZATION UNIT (Recruiting Station)	
12. DATE OF BIRTH 4 APR 60 (22)		13. PLACE OF BIRTH Hometown, USA		14. NAME, RELATIONSHIP, AND ADDRESS OF, NEXT OF KIN John F. Doe (F) 1234 Main St., Anywhere, Anystate ZIP	
15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS NAS Anywhere ZIP		16. OTHER INFORMATION Religion: See art. 16-38(2)(p)			
17. RATING OR SPECIALTY LEAVE BLANK		TIME IN THIS CAPACITY (Total) LEAVE BLANK		LAST SIX MONTHS LEAVE BLANK	

CLINICAL EVALUATION		ABNOR. MAL
X	18. HEAD, FACE, NECK AND SCALP	
X	19. NOSE	
X	20. SINUSES	
X	21. MOUTH AND THROAT	
X	22. EARS—GENERAL (Int & ext canals) (Auditory acuity under items 70 and 71)	
X	23. DRUMS (Perforation)	
X	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 61)	
X	25. OPHTHALMOSCOPIC	
X	26. PUPILS (Equality and reaction)	
X	27. OCULAR MOTILITY (Associated paralytic movements, nystagmus)	
X	28. LUNGS AND CHEST (Include breasts)	
X	29. HEART (Thrust, size, rhythm, sounds)	
X	30. VASCULAR SYSTEM (Varicosities, etc.)	
X	31. ABDOMEN AND VISCERA (Include hernia)	
X	32. ANUS AND RECTUM (Hemorrhoids, fistulas) (Prostate if indicated)	
X	33. ENDOCRINE SYSTEM	
X	34. G-U SYSTEM	
X	35. UPPER EXTREMITIES (Strength, range of motion)	
X	36. FEET	
X	37. LOWER EXTREMITIES (Excluding feet) (Strength, range of motion)	
X	38. SPINE, OTHER MUSCULOSKELETAL	
X	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	X
X	40. SKIN, LYMPHATICS	
X	41. NEUROLOGIC (Equilibrium tests under item 72)	
X	42. PSYCHIATRIC (Specify any personality deviation)	
	43. PELVIC (Females only) (Check how done)	
	<input type="checkbox"/> VAGINAL <input type="checkbox"/> RECTAL	

NOTES (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

Aeronautical Adaptability: Favorable
Self-Balancing Test: Steady
Reading Aloud Test: Clear and well modulated

#39 (identifying body marks) - (see art. 16-39)

44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)																REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES	
<div style="display: flex; justify-content: space-around;"> <div> 0 1 2 3 Restorable teeth 32 31 30 </div> <div> 1 2 3 Non-restorable teeth 32 31 30 </div> <div> 2 3 Missing teeth 32 31 30 </div> <div> 1 2 3 Replaced by dentures 32 31 30 </div> <div> 1 2 3 Fixed partial dentures 32 31 30 </div> </div>																TYPE 1	
<div style="display: flex; justify-content: space-between;"> <div> R 1 2 3 4 5 6 7 8 G 32 31 30 29 28 27 26 25 H T </div> <div> 9 10 11 12 13 14 15 16 24 23 22 21 20 19 18 17 F </div> </div>																Class 1	
																ACCEPTABLE	

LABORATORY FINDINGS			
45. URINALYSIS: A. SPECIFIC GRAVITY 1.010		46. CHEST X-RAY (Place, date, film number and result)	
B. ALBUMIN NEG		NAS Anywhere	
C. SUGAR NEG		19 APR 82 - 1682 - NEGATIVE	
47. SEROLOGY (Specify test used and result)		48. EKG	
19 APR 82		"WNL"	
VDRL-NON-REACTIVE		49. BLOOD TYPE AND RH FACTOR	
		0+	
		50. OTHER TESTS	
		HEMATOCRIT - 44%	
		Sickle Cell Screen - NEGATIVE	

Illustration 1B. Standard Form 88, Report of Aviation Candidate Medical Examination (Front)

SH - 37.5(95.25) BKL - 24.0(60.96)

BL - 45(114.30) FR - 31.0(78.74) MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT 69" (177.80)		52. WEIGHT 170 (76.50)		53. COLOR HAIR Brown		54. COLOR EYES Blue		55. BUILD: <input type="checkbox"/> SLENDER <input checked="" type="checkbox"/> MEDIUM <input type="checkbox"/> HEAVY <input type="checkbox"/> OBESE		56. TEMPERATURE 98.6 (37.3)	
57. BLOOD PRESSURE (Arm at heart level)						58. PULSE (Arm at heart level)					
A. SITTING SYS. 126 DIA. 86		B. RECUMBENT SYS. 126 DIA. 86		C. STANDING (3 min.) SYS. 122 DIA. 86		A. SITTING		B. AFTER EXERCISE		C. 2 MIN. AFTER	
										68 78	
59. DISTANT VISION						60. REFRACTION CYCLOPLEGIC					
RIGHT 20/ 20		CORR. TO 20/ 20		BY +0.50 S.		CX		20		CORR. TO	
LEFT 20/ 20		CORR. TO 20/ 20		BY +0.50 S.		CX		20		CORR. TO	
62. METROPHORIA (Specify distance) 20" (60m) (SNFO---NOHOSH)-See art. 15-69(3)(a)(3)											
ES° 0.0		EX° 0.0		R. H. 0.0		L. H. 0.0		PRISM DIV. CT		PRISM CONV. CT	
63. ACCOMMODATION RIGHT 10.9 LEFT 10.4		64. COLOR VISION (Test used and result) FALANT Passed						65. DEPTH PERCEPTION (Test used and score) AFVT		UNCORRECTED Passed D CORRECTED	
66. FIELD OF VISION N						67. NIGHT VISION (Test used and score)					
68. RED LENS TEST						69. INTRAOCULAR TENSION N					
70. HEARING						71. ISO 1964 AUDIOMETER					
RIGHT WV /15 SV /15						350 500 1000 2000 3000 4000 6000 8000					
LEFT WV /15 SV /15						RIGHT XX 5 10 10 10 5 10 XX LEFT XX 0 5 10 5 10 20 XX					
72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)											

73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

Flight Surgeon's Evaluation: Candidate presents an excellent appearance. He is aggressive and has participated actively in organized school athletics. He has had an interest in flying since a child and has flown as a passenger in small private aircraft without difficulty. He is well motivated and is recommended for flight training. (See art. 15-68(3))

BVE: UNCORRECTED - 100%
CORRECTED - 100%

#65: Or - Verhoeff - UNCORRECTED 100% (Additional sheets if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

#39: (identifying body marks) - NCD

(LEAVE BLANK FOR

NAVMEDCOM ENDORSEMENT)

LEAVE BLANK FOR

NAVMEDCOM ENDORSEMENT)

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

77. EXAMINEE (Check)

A. ☒ IS QUALIFIED FOR 1s PQ and AA for (DIACA SNA) (DIF SNFO, SFS)

B. ☐ IS NOT QUALIFIED FOR (DUTY A/C) and to perform all duties of his rate at sea and in field.

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

79. TYPED OR PRINTED NAME OF PHYSICIAN

J. E. POOLE LT MC USNR

80. TYPED OR PRINTED NAME OF PHYSICIAN

81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which)

V. L. SHOWALTER LT DC USN

82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY

G. W. DWYER CAPT MC USN

SIGNATURE

SIGNATURE

SIGNATURE

SIGNATURE

SIGNATURE

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

B. PHYSICAL CATEGORY

A	B	C	E

NUMBER OF ATTACHED SHEETS

U.S. GOVERNMENT PRINTING OFFICE : 1981 O - 361-526 (7301)

Illustration 1C. Standard Form 88, Report of Aviation Candidate Medical Examination (Back)

Standard Form 88
Revised 10/75
General Services Administration
Interagency Comm. on Medical Records
FPMR 101-11.806-8

REPORT OF MEDICAL EXAMINATION

AVIATION

1. LAST NAME—FIRST NAME—MIDDLE NAME DOE, John Dee			2. GRADE AND COMPONENT OR POSITION LT USN Desig.		3. IDENTIFICATION NO. 444-44-4444	
4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code) 1234 Main Street Anywhere, Anystate ZIP			5. PURPOSE OF EXAMINATION Annual Flight		6. DATE OF EXAMINATION 19 JAN 82	
7. SEX Male	8. RACE Cauc. Negroid, etc.	9. TOTAL YEARS GOVERNMENT SERVICE MILITARY 4y4m LEAVE BLANK	10. AGENCY DOD	11. ORGANIZATION UNIT VF 192, NAS Miramar, CA 92145		
12. DATE OF BIRTH 4 JAN 50 (32)		13. PLACE OF BIRTH Hometown, USA		14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN Mary J. DOE (wife) Same as #4		
15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS NAS Anywhere ZIP			16. OTHER INFORMATION Religion See art. 16-38(2)(p)			
17. RATING OR SPECIALTY NA, NFO, FS, AC, or ATC SEP 74			TIME IN THIS CAPACITY (Total) 1280 hours		LAST SIX MONTHS 160 hours	

CLINICAL EVALUATION		ABNOR- MAL
(Check each item in appropriate column, enter "NE" if not evaluated.)		
X	18. HEAD, FACE, NECK AND SCALP	
X	19. NOSE	
X	20. SINUSES	
X	21. MOUTH AND THROAT	
X	22. EARS—GENERAL (Int. & ext. canals) (Auditory acuity under items 70 and 71)	
X	23. DRUMS (Perforation)	
X	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 61)	
X	25. OPHTHALMOSCOPIC	
X	26. PUPILS (Equality and reaction)	
X	27. OCULAR MOTILITY (Associated parallel movement, nystagmus)	
X	28. LUNGS AND CHEST (Include breasts)	
X	29. HEART (Thrust, size, rhythm, sounds)	
X	30. VASCULAR SYSTEM (Varicosities, etc.)	
X	31. ABDOMEN AND VISCERA (Include hernia)	
X	32. ANUS AND RECTUM (Hemorrhoids, fistulae) (Fistulae, if indicated)	
X	33. ENDOCRINE SYSTEM	
X	34. G-U SYSTEM	
X	35. UPPER EXTREMITIES (Strength, range of motion)	
X	36. FEET	
X	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
X	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS SCARS, TATTOOS	X
X	40. SKIN, LYMPHATICS	
X	41. NEUROLOGIC (Equilibrium tests under item 78)	
X	42. PSYCHIATRIC (Specify any personality deviation)	
	43. PELVIC (Females only) (Check how done)	
	<input type="checkbox"/> VAGINAL <input type="checkbox"/> RECTAL	

NOTES (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

Aeronautical Adaptability: Favorable
Self-Balancing Test: Steady
Reading Aloud Test: Clear and well modulated

#2 See Manual of Navy Officer Manpower and Personnel Classification (NAVPERS 15839c)

#39 (identifying body marks) - (see art. 16-39)

44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)																		REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES	
<div style="display: flex; justify-content: space-around; font-size: small;"> 0 1 2 3 Restorable teeth 1 2 3 Non-restorable teeth 1 2 3 Missing teeth 1 2 3 Replaced by dentures 1 2 3 Fixed Partial dentures </div>																		TYPE I CLASS I ACCEPTABLE	
<div style="display: flex; justify-content: space-between;"> <div style="text-align: center;"> R I G H T 1 2 3 4 5 6 7 8 32 31 30 29 28 27 26 25 </div> <div style="text-align: center;"> L E F T 9 10 11 12 13 14 15 16 24 23 22 21 20 19 18 17 </div> </div>																			

LABORATORY FINDINGS			
45. URINALYSIS: A. SPECIFIC GRAVITY 1.010		46. CHEST X-RAY (Place, date, film number and result) NAS Anywhere (if required) 19 JAN 82 - 1845 - NEGATIVE	
B. ALBUMIN NEG		D. MICROSCOPIC ESS NEG	
C. SUGAR NEG		48. BLOOD TYPE AND RH FACTOR O+	
47. SEROLOGY (Specify test used and result) 19 JAN 82 WDL-NON-REACTIVE		49. OTHER TESTS HEMATOCRIT - 46%	

Illustration 1D. Standard Form 88, Report of Aviation Annual Medical Examination (Front)

MEASUREMENTS AND OTHER FINDINGS											
51. HEIGHT 70" (177.80)		52. WEIGHT 170 (76.50)		53. COLOR HAIR Brown		54. COLOR EYES Blue		55. BUILD: <input type="checkbox"/> SLENDER <input checked="" type="checkbox"/> MEDIUM <input type="checkbox"/> HEAVY <input type="checkbox"/> OBESE		56. TEMPERATURE 98.6 (37.3)	
57. BLOOD PRESSURE (Arm at heart level)						58. PULSE (Arm at heart level)					
A. SITTING SYS. 130 DIAS. 80		B. RECUMBENT SYS. 130 DIAS. 80		C. STANDING (3 min.) SYS. 138 DIAS. 88		A. SITTING		B. AFTER EXERCISE		C. 2 MIN. AFTER	
D. RECUMBENT		E. AFTER STANDING 3 MIN.									
59. DISTANT VISION				60. REFRACTION				61. NEAR VISION			
RIGHT 20/ 20 CORR. TO 20/				BY See arts 15-62 (21) (22)				20 CORR. TO			
LEFT 20/ 20 CORR. TO 20/				BY S. CX				20 CORR. TO			
62. METEOPHORIA (Specify distance) 20' (NFO---NOHOSH)											
ES° 4.0		EX° 0.0		R. H. 0.0		L. H. 0.0		PRISM DIV.		PRISM CONV. CT	
63. ACCOMMODATION		64. COLOR VISION (Test used and result)				65. DEPTH PERCEPTION (Test used and score)		UNCORRECTED Passed D			
RIGHT LEFT		FALANT passed				AFVT		CORRECTED			
66. FIELD OF VISION				67. NIGHT VISION (Test used and score)				68. RED LENS TEST		69. INTRAOCULAR TENSION	
N										N	
70. HEARING				71. AUDIOMETER						72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)	
RIGHT WV /15 SV /15				350 500 1000 2000 3000 4000 6000 8000							
				RIGHT XX 10 5 5 10 60 20 XX							
LEFT WV /15 SV /15				LEFT XX 5 5 10 10 40 15 XX							
73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY											
(LEAVE BLANK FOR NAVMEDCOM ENDORSEMENT)											
#65: Or-Verhoeff-uncorrected-16/16											
#69: Or-TOD 5.5Gm-14.0 mmHg TOS 5.5Gm-14.5 mmHg											
(Use additional sheets if necessary)											
74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)											
#39: (identifying body marks) - NCD (LEAVE BLANK FOR NAVMEDCOM ENDORSEMENT)											
#71: Defective Auditory Acuity: High frequency ranges, AU-NCD											
75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify) (If distant visual Acuity is corrected and correction is required.) Corrective glasses to be worn at all times while flying.											
76. A. PHYSICAL PROFILE											
P U L H E S											
B. PHYSICAL CATEGORY											
A B C E											
77. EXAMINEE (Check) Is PQ and AA for (DIACA SG I, SG II, SG III) (NIACA)											
A. <input checked="" type="checkbox"/> IS QUALIFIED FOR (DIF NFO, FS) (DUTY A/C) and to perform all duties of his rate at sea and in the field.											
B. <input type="checkbox"/> IS NOT QUALIFIED FOR											
78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER											
79. TYPED OR PRINTED NAME OF PHYSICIAN G. T. SEA, LT MC USNR						SIGNATURE G.T. Sea					
80. TYPED OR PRINTED NAME OF PHYSICIAN						SIGNATURE					
81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which) W. L. GARDNER LT DC USN						SIGNATURE W.L. Gardner					
82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY L. M. PURDY CAPT MC USN						SIGNATURE L.M. Purdy					
						NUMBER OF ATTACHED SHEETS					

U.S. GOVERNMENT PRINTING OFFICE : 1981 O - 361-526 (7301)

Illustration 1E. Standard Form 88, Report of Aviation Annual Medical Examination (Back).

STANDARD FORM 93
REV. OCTOBER 1974
GSA FPMR 101-11.6

APPROVED
OFFICE OF MANAGEMENT AND BUDGET No. 25-R0191

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME DOE, John James				2. SOCIAL SECURITY OR IDENTIFICATION NO. 987-65-4321			
3. HOME ADDRESS (No. street or RFD, city or town, State, and ZIP CODE) 444 West Street, Bay City, N.Y. 11709				4. POSITION (title, grade, component) See art. 16-38(2)			
5. PURPOSE OF EXAMINATION See art. 16-38(2)		6. DATE OF EXAMINATION 1 MAY 82		7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS (Include ZIP Code) Naval Station, Blank, VA 23708			
8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint exists) <i>I'm in excellent health and do not currently take any medications.</i>							
9. HAVE YOU EVER (Please check each item)				10. DO YOU (Please check each item)			
YES	NO	(Check each item)		YES	NO	(Check each item)	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Lived with anyone who had tuberculosis		<input checked="" type="checkbox"/>	<input type="checkbox"/>	Wear glasses or contact lenses	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Coughed up blood		<input checked="" type="checkbox"/>	<input type="checkbox"/>	Have vision in both eyes	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Bled excessively after injury or tooth extraction		<input checked="" type="checkbox"/>	<input type="checkbox"/>	Wear a hearing aid	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Attempted suicide		<input checked="" type="checkbox"/>	<input type="checkbox"/>	Stutter or stammer habitually	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Been a sleepwalker		<input checked="" type="checkbox"/>	<input type="checkbox"/>	Wear a brace or back support	
11. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item)							
YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever, erysipelas	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cramps in your legs
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent indigestion
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen or painful joints	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach, liver, or intestinal trouble
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or severe headache	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble or gallstones
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting spells	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice or hepatitis
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adverse reaction to serum, drug, or medicine
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear, nose, or throat trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, growth, cyst, cancer
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic or frequent colds	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rupture/hernia
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe tooth or gum trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Piles or rectal disease
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or painful urination
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bed wetting since age 12
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head injury	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stone or blood in urine
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin diseases	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sugar or albumin in urine
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VD—Syphilis, gonorrhea, etc.
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recent gain or loss of weight
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis, Rheumatism, or Bursitis
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bone, joint or other deformity
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain or pressure in chest	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lameness
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of finger or toe
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Palpitation or pounding heart	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful or "trick" shoulder or elbow
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent back pain
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High or low blood pressure	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. WHAT IS YOUR USUAL OCCUPATION? <i>High School Student</i>				14. ARE YOU (Check one) <input checked="" type="checkbox"/> Right handed <input type="checkbox"/> Left handed			

93-102

Illustration 2. Standard Form 93, Report of Medical History (Front)

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT		
✓		15. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sun-light, etc.		
✓		B. Inability to perform certain motions.		
✓		C. Inability to assume certain positions.		
✓		D. Other medical reasons (If yes, give reasons.)		
✓		16. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.)		
✓		17. Have you ever been denied life insurance? (If yes, state reason and give details.)		
✓		18. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.)		
✓		19. Have you ever been a patient in any type of hospitals? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)		
✓		20. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)		
✓		21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)		
✓		22. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.)		
✓		23. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.)		
✓		24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.)		
<p>I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.</p>				
TYPED OR PRINTED NAME OF EXAMINEE		SIGNATURE		
John James Doe		John James Doe		
<p>NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY." 25. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)</p>				
<p>Several bouts of tonsillitis in early childhood - no problems in past 2-3 years - Throat clear. F/S rt tibia Oct 77 football injury - normal Rx and followup - no comp or seq.</p>				
TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER		DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
William R. Stack LT MC USN		1 May 82	William R. Stack	0
REVERSE OF STANDARD FORM 93				

Illustration 2A. Standard Form 93, Report of Medical History (Back)

HEALTH RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE																																	
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)																																		
1 DEC 82	NAVAL HOSPITAL, BLANK, VA																																		
	<p>Member cut forehead when he slipped in shower and struck head on edge of shower stall. 1" (2.54 cm) laceration over left eyebrow. Wound cleaned and sutured with six 6-0 nylon sutures. Tetanus Toxoid booster given. To duty. To return to sick call on 6 Dec 1982.</p> <p style="text-align: right;">W.T. Sloor LCDR, MC, USNR</p>																																		
6 DEC 82	NAVAL HOSPITAL, BLANK, VA																																		
	<p>Forehead laceration healing well. Sutures removed. No other complaints. To duty.</p> <p style="text-align: right;">W.T. Sloor LCDR, MC, USNR</p>																																		
10 JAN 83	NAVAL HOSPITAL, BLANK, VA																																		
	<p>Health and Dental Records screened. Physically qualified for transfer.</p> <p style="text-align: right;">Calvin J. Richards HMI C. J. RICHARDS, USN</p>																																		
23 FEB 83	USS CARRIER (CV-00)																																		
	<p>Transcribed from DD 689 - NAS Dispensary, Blank, VA dated 21 FEB 1983.</p>																																		
PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)		<table border="1"> <tr> <td colspan="3">PATIENT'S NAME (Last, First, Middle initial)</td> <td>SEX</td> </tr> <tr> <td colspan="3">DOE, John J.</td> <td>M</td> </tr> <tr> <td>YEAR OF BIRTH</td> <td>RELATIONSHIP TO SPONSOR</td> <td>COMPONENT/STATUS</td> <td>DEPART/SERVICE</td> </tr> <tr> <td>9 MAY 58</td> <td>N/A</td> <td>AD</td> <td>USN</td> </tr> <tr> <td colspan="3">SPONSOR'S NAME</td> <td>RANK/GRADE</td> </tr> <tr> <td colspan="3">N/A</td> <td>HM3</td> </tr> <tr> <td colspan="2">SSAN OR IDENTIFICATION NO</td> <td colspan="2">ORGANIZATION</td> </tr> <tr> <td colspan="2">987-65-4321</td> <td colspan="2">Fighter Sq.-VF 143</td> </tr> </table>		PATIENT'S NAME (Last, First, Middle initial)			SEX	DOE, John J.			M	YEAR OF BIRTH	RELATIONSHIP TO SPONSOR	COMPONENT/STATUS	DEPART/SERVICE	9 MAY 58	N/A	AD	USN	SPONSOR'S NAME			RANK/GRADE	N/A			HM3	SSAN OR IDENTIFICATION NO		ORGANIZATION		987-65-4321		Fighter Sq.-VF 143	
PATIENT'S NAME (Last, First, Middle initial)			SEX																																
DOE, John J.			M																																
YEAR OF BIRTH	RELATIONSHIP TO SPONSOR	COMPONENT/STATUS	DEPART/SERVICE																																
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SPONSOR'S NAME			RANK/GRADE																																
N/A			HM3																																
SSAN OR IDENTIFICATION NO		ORGANIZATION																																	
987-65-4321		Fighter Sq.-VF 143																																	

CHRONOLOGICAL RECORD OF MEDICAL CARE

Standard Form 680
16-7400-106

Illustration 3. Standard Form 600, Chronological Record of Medical Care (Front)

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
5 MAR 83	<p>"Member injured right hand when he struck hand on backboard during COMNAVIRLANT basketball game at 2030 this date, X-ray of right hand negative for fracture or dislocation. Impression: Contusion rt. hand. Treatment: Hot soaks for next several days and ASA 10 gr q4h prn for pain. To duty. /s/ CDR T. R. JONES, MC, USNR"</p> <p style="text-align: right;"><i>N. L. Contos</i> HM2 N. L. CONTOS, USN</p>
19 MAR 83	<p>USS CARRIER (CV-00)</p> <p>DIAGNOSIS: Contusion, left thoracic region. ICDA Code No. 9220</p> <p>Line of duty. Not due to own misconduct.</p> <p>While descending hatchway, slipped and fell, striking left chest against hatch combing.</p> <p>Patient complains of shortness of breath with pain and discomfort in left thoracic region.</p> <p>Examination indicates possibility of internal injuries, and as this ship is leaving port tomorrow on extended operation, it is deemed medically advisable to transfer this patient to a hospital.</p>
19 MAR 83	<p>Transferred to Naval Hospital, Blank, VA</p> <p style="text-align: right;"><i>S. B. Shue</i> S. B. SHUE, LT MC USN</p> <p>APPROVED:</p> <p style="text-align: center;"><i>P. M. Paula</i> P. M. PAULA CAPT MC USN</p>
19 MAR 83	<p>NAVAL HOSPITAL, BLANK, VA</p> <p>DIAGNOSIS: Contusion, left thoracic region. ICDA Code No. 9220</p> <p>Line of duty. Not due to own misconduct.</p> <p>Admitted from USS CARRIER (CV-00) where while descending hatchway, patient slipped and fell, striking left chest against hatch combing.</p> <p>Complains of shortness of breath and severe pain in area of 4th thoracic rib.</p> <p>X-RAY: Examination of entire right and left thoracic regions, reveals no evidence of fracture or bone pathology.</p> <p>TREATMENT: Heat application and bed rest.</p> <p>Slight pain with motion. Discomfort subsiding.</p> <p>On 24 Mar 83 patient developed acute sore throat.</p> <p>Temp. 101.2 (38.7); pharynx injected, tonsils inflamed. Exudate cultured.</p> <p>DIAGNOSIS CHANGED on 26 Mar 83 by reason of intercurrent diagnosis.</p> <p>Tonsillitis, Acute, Streptococcal, ICDA Code No. 4630</p> <p>Line of Duty. Not due to own misconduct.</p> <p>Placed on an antibiotic therapy. (Penicillin)</p> <p>On 1 May 83 Temp. 98.6 (37.3); all medication discontinued. Slight discomfort and tenderness remain in left thoracic region. Ward privileges authorized.</p>
4 MAY 83	<p>No complaints. To duty. Well.</p> <p style="text-align: right;"><i>R. M. Gaines</i> R. M. GAINES, LT MC USN</p> <p>APPROVED:</p> <p style="text-align: center;"><i>L. E. Laura</i> L. E. LAURA CHIEF, SERVICE</p>

Illustration 3A. Standard Form 600, Chronological Record of Medical Care (Back)

1. The first part of the report discusses the general situation of the country and the progress of the work during the year. It also mentions the results of the various committees and the work of the different departments.

2. The second part of the report deals with the financial situation of the country. It gives a detailed account of the income and expenditure of the government and the different departments. It also mentions the results of the various financial committees and the work of the different departments.

3. The third part of the report discusses the progress of the various committees and the work of the different departments. It mentions the results of the various committees and the work of the different departments.

4. The fourth part of the report deals with the progress of the various committees and the work of the different departments. It mentions the results of the various committees and the work of the different departments.

5. The fifth part of the report discusses the progress of the various committees and the work of the different departments. It mentions the results of the various committees and the work of the different departments.

6. The sixth part of the report deals with the progress of the various committees and the work of the different departments. It mentions the results of the various committees and the work of the different departments.

7. The seventh part of the report discusses the progress of the various committees and the work of the different departments. It mentions the results of the various committees and the work of the different departments.

8. The eighth part of the report deals with the progress of the various committees and the work of the different departments. It mentions the results of the various committees and the work of the different departments.

9. The ninth part of the report discusses the progress of the various committees and the work of the different departments. It mentions the results of the various committees and the work of the different departments.

10. The tenth part of the report deals with the progress of the various committees and the work of the different departments. It mentions the results of the various committees and the work of the different departments.

HEALTH RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE	
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)		
2 APR 81	USS NEVER SAIL APC 14 FPO NY, NY SF 502 of 15 FEB 81 from NH Overthehill found to be in error. Entry states that RM2 JONES had an arthroplasty performed on his right knee. An examination of RM2 JONES this date shows no surgical scar on his right knee. Exam did reveal, however, surgical scar on his left knee. <i>R. C. Pantell</i> R. C. PANTELL LCDR, MC, USNR		
15 APR 81	USS NEVER SAIL APC 14 FPO NY, NY <i>Complaining of pain in his lower back for past six^{five} days. Area tender and slight redness found in lower back area. To see MO.</i> <i>P.E. Dast</i> HM3/USN		
PATIENT'S IDENTIFICATION (Use this Space for Mechanical Imprint)			
PATIENT'S NAME (Last, First, Middle initial) JONES, ROBERT F.			SEX M
YEAR OF BIRTH 13 JUN 60	RELATIONSHIP TO SPONSOR	COMPONENT/STATUS AD	DEPART/SERVICE USN
SPONSOR'S NAME			RANK/GRADE RM2
SSAN OR IDENTIFICATION NO. 000-00-0000			ORGANIZATION USS NEVER SAIL APC 14

CHRONOLOGICAL RECORD OF MEDICAL CARE

Standard Form 600
500-106

Illustration 3B. Standard Form 600, Chronological Record of Medical Care (Front)

HEALTH RECORD**IMMUNIZATION RECORD***All entries in ink to be made in block letters***VACCINATION AGAINST SMALLPOX** (Number of previous vaccination scars)

	DATE	ORIGIN	BATCH NUMBER	REACTION	STATION	PHYSICIAN'S NAME
1	5Jan82	Eli Lilly	L 292 856	None	NTC Bainbridge, MD	J. A. Jones
2	10Feb83	Parke-Davis	A 464 25	None	USS Good Ship	T. P. Brown
3	5Jun84	Eli Lilly	P 311 421	None	USS Good Ship	T. P. Brown
4						
5						
6						

YELLOW FEVER VACCINE

	DATE	ORIGIN	BATCH NUMBER	STATION	PHYSICIAN'S NAME
1	28Jan83	Nat'l Drug Company	Y 0101	Naval Base, Norfolk, VA	A. M. Doe
2					
3					

TYPHOID VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1	5Jan82	0.5cc	J. A. Jones	4	8Mar83	0.5cc	T. P. Brown
2	12Jan82	0.5cc	J. A. Jones	5			
3	30Jan82	0.5cc	J. A. Jones	6			

TETANUS-DIPHTHERIA TOXOIDS

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1	6Jan82	0.5cc	J. A. Jones	4	16Dec82	0.5cc	A. M. Doe
2	6Feb82	0.5cc	J. A. Jones	5	5Jan83	1.0cc	A. M. Doe
3	4Dec82	0.1cc	A. M. Doe	6	5Feb83	1.0cc	A. M. Doe

CHOLERA VACCINE

	DATE	PHYSICIAN'S NAME		DATE	PHYSICIAN'S NAME		DATE	PHYSICIAN'S NAME
1	7Jan83	A. M. Doe	4			7		
2	14Jan83	A. M. Doe	5			8		
3			6			9		

PATIENT'S IDENTIFICATION (Mechanically Imprint, Type or Print):

Doe, John J.
Male 9 May 60
AD USN
987-65-4321

◀ Patient's Name—last, first, middle initial;
Sex; Age or Year of Birth; Relationship to Sponsor;
Component/Status; Department/Service.

◀ Sponsor's Name—last, first, middle initial;
Rank/Grade; SSN or Identification Number;
Organization.

601-104

IMMUNIZATION RECORD
Standard Form 601—October 1975
General Services Administration and
Interagency Committee on Medical Records
FPMR 101-11.806-8

Illustration 4. Standard Form 601, Immunization Record (Front)

ORAL POLIOVIRUS VACCINE							
	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				3			
2				4			

INFLUENZA VACCINE							
	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1	15Nov81	1.0cc	T. P. Brown	3			
2				4			

OTHER IMMUNIZATIONS									
	DATE	TYPE	DOSE	PHYSICIAN'S NAME		DATE	TYPE	DOSE	PHYSICIAN'S NAME
1	27Dec81	Poliomy- elitis	1.0cc	J. A. Jones	5	10Oct82	Poliomy- elitis	1.0cc	T. P. Brown
2	9Jan82	Typhus	1.0cc	A. M. Doe	6	10Mar83	Plague	0.5cc	T. P. Brown
3	26Jan82	Poliomy- elitis	1.0cc	A. M. Doe	7	15Apr84	Plague	1.0cc	T. P. Brown
4	30Jan82	Typhus	1.0cc	A. M. Doe	8				

SENSITIVITY TESTS (Tuberculin, etc.)						
	DATE	TYPE	DOSE	ROUTE	RESULTS	PHYSICIAN'S NAME
1	7Jan81	Tuberculin (PPD)	5 t.u.	Intracutaneous	0 M M	J. A. Jones
2						
3						
4						
5						

REMARKS:

- (1) HYPERSENSITIVE TO ASPIRIN.
- (2) HISTORY MODERATELY SEVERE REACTION TO PARENTERAL PENICILLIN IN 1980.

THIS RECORD IS ISSUED IN ACCORDANCE WITH ARTICLE 99, WHO SANITARY REGULATION NO. 2.

U.S. GOVERNMENT PRINTING OFFICE : 1976 O - 241-530

Illustration 4A. Standard Form 601, Immunization Record (Back)

HEALTH RECORD

SYPHILIS RECORD

SECTION I.—HISTORY OF PAST VENEREAL INFECTIONS OR TREATMENTS

DATE	DISEASE (Give stage)	PRIOR TO MIL SERVICE		TREATMENT (Give type, amount and dates)	TREATING AGENCY	PLACE
		YES	NO			
1						
2				NONE		
3						
4						

SECTION II.—HISTORY OF PRESENT INFECTION

CAME TO MEDICAL ATTENTION BY VOLUNTARY <input checked="" type="checkbox"/>	CONTACT REPORT <input type="checkbox"/>	PHYSICAL INSPECTION <input type="checkbox"/>	FOOD HANDLER <input type="checkbox"/>
INCIDENT TO HOSPITALIZATION <input type="checkbox"/>	PREMARITAL <input type="checkbox"/>	PRENATAL <input type="checkbox"/>	OTHER (Specify) <input type="checkbox"/>
DATES ONSET SYMPTOMS 7 JAN 82	REQUESTED TREATMENT 10 JAN 82	DIAGNOSIS ESTABLISHED 10 JAN 82	OUTPATIENT TREATMENT
DIAGNOSIS (Include stage and diagnostic No.) SYPHILIS, primary, seronegative #091.0 (chancere, glans penis).		DIAGNOSTIC CRITERIA (Enter results of tests) DARKFIELD POS 10 JAN 82 S.T.S. VDRL - Neg SPINAL FLUID (If indicated) OTHER (Last)	
LIST VD CONTACT FORM SERIAL NOS. B 126696			

CLINICAL DATA (Include chief complaint, physical findings—eye, cardiovascular and nervous system, even in early syphilis)

Hard "sore" on penis for 3 days. No other symptoms. In addition to a 1 cm. ulcer with markedly indurated base on glans penis has slightly enlarged, non-tender, hard inguinal lymph nodes.

RECOMMENDED TREATMENT AND FOLLOW-UP

Penicillin Therapy - Standard 1 year followup

W. T. Hatch
W. T. HATCH LT MC USN 18 JAN 82

I HAVE BEEN INFORMED BY THE MEDICAL OFFICER THAT I HAVE BEEN DIAGNOSED AS HAVING SYPHILIS AS INDICATED ABOVE. THE NATURE OF THIS DISEASE HAS BEEN EXPLAINED TO ME. I UNDERSTAND THAT MY COOPERATION IS NECESSARY IN THE TREATMENT AND PROLONGED OBSERVATION (including certain prescribed tests) FOR THE CARE OF THIS DISEASE.

SIGNATURE OF PATIENT AND DATE
John James Doe
John James DOE 18 JAN 82

SECTION III.—TREATMENT

TREATMENT	DATE STARTED	DATE ENDED	SIGNATURE OF PHYSICIAN
1 Benzathine Pen G. 2,400,000 U	10 JAN 82	10 JAN 82	<i>W. T. Hatch</i> W. T. HATCH LT MC USN
2			
3			
4			

PATIENT'S IDENTIFICATION (Mechanically Imprint, Type or Print):

DOE, John James
HM1; 987-65-4321
USS DESTROYER (DD-21)

602-104

◀ Patient's Name—last, first, middle initial;
Sex; Age or Year of Birth; Relationship to Sponsor;
Component/Status; Department/Service.

◀ Sponsor's Name—last, first, middle initial;
Rank/Grade; SSN or Identification Number;
Organization.

SYPHILIS RECORD
Standard Form 602—March 1975 (Rev.)
General Services Administration &
Interagency Comm. on Medical Records
FPMR 101-11.809-3

Illustration 5. Standard Form 602, Syphilis Record (Front)

SECTION IV.—CUMULATIVE LABORATORY SUMMARY									
RESULTS OF DARKFIELD EXAMINATION									
	DATE	RESULTS	SOURCE OF SPECIMEN	LABORATORY	NAME OF CONFIRMING OFFICER				
1	10JAN82	POSITIVE	PENILE LESION	NS BLANK VA	W.T. HATCH, LT MC USN				
2	15JAN82	NEGATIVE	HEALING PENILE LESION	NS BLANK VA	W.T. HATCH, LT MC USN				
RESULTS OF SEROLOGICAL TESTS FOR SYPHILIS									
	DATE	TYPE	RESULT (Include titer value)	LABORATORY		DATE	TYPE	RESULT (Include titer value)	LABORATORY
1	10JAN82	VDRL	Negative	NS Blank VA	5	17 JAN 83	VDRL	Negative	USS DESTROYER
2	10MAR82	VDRL	Negative	NS Blank VA	6				
3	15MAY82	VDRL	Negative	NS Blank VA	7				
4	17JUL82	VDRL	Negative	NS Blank VA	8				
FLUORESCENT ANTIBODY TESTS									
	DATE								
1									
2									
RESULTS OF SPINAL FLUID EXAMINATIONS									
	DATE	CELLS	TOTAL PROTEIN	SEROLOGICAL TESTS (Including titer)				LABORATORY WHERE DONE	
1	15JUL82	0-1	30 mg	VDRL Negative				NS Blank VA	
2									
SECTION V.—EVALUATION OF THERAPY									
	DATE	FACILITY WHERE EVALUATED	RESULT		DATE OF RETREATMENT	PHYSICIAN'S SIGNATURE			
			Satisfactory*	UNSATISFACTORY**					
1	15JUL82	NS Blank VA	X		None	W.T. Hatch			
2	15MAR83	NS Blank VA	X		None	W.T. Hatch			
3	15APR84	USS ORO (DD-0)	X		None	C. O. Brewster			
4	28DEC84	NS Blank VA	X		None	W.T. Hatch			
*Satisfactory result cannot be reported without normal spinal fluid findings									
**Specify: Infectious Relapse, Serologic Relapse, Neuro-Relapse, Incomplete data on Spinal Fluid, Other (Specify)									
REASON FOR INADEQUATE FOLLOW-UP (Date, place and type of separation—Give authority for discharge)									
PATIENT'S HOME ADDRESS ON SEPARATION					CIVILIAN HEALTH DEPT. TO WHICH CASE RESUME WAS SENT				
2619 Flower St. Anytown, USA					Anytown, USA				
REINFECTION (Give date new record was opened)									
REMARKS (Include significant posttreatment clinical findings)									
SECTION VI.—MEDICAL OFFICER CLOSING THIS RECORD									
A.A. FINE, CDR MC USN		A.A. Fine		NS Blank VA		28 DEC 84			
NAME (Typed or printed)		SIGNATURE		STATION		DATE			
SECTION VII.—MEDICAL OFFICER SENDING ABSTRACT TO VETERANS ADMINISTRATION ON DISCHARGE									
A.A. FINE, CDR MC USN		A.A. Fine		NS Blank VA		28 DEC 84			
NAME (Typed or printed)		SIGNATURE		STATION		DATE			

Illustration 5A. Standard Form 602, Syphilis Record (Back)

ABSTRACT OF SERVICE AND MEDICAL HISTORY
NAVMED 6150/4 (Rev. 12-67) S/N. 0105.209.5040
(Formerly NAVMED 1406)

[illegible]

Illustration 6. NAVMED 6150/4, Abstract of Service and Medical History

NAVJED-6150/2 (Rev. 4-70)
(Formerly NAVJED 1346)
S/N-0105-209-5021

HEALTH RECORD			SPECIAL DUTY MEDICAL ABSTRACT				
SUMMARY OF PHYSICAL EXAMINATIONS FOR SPECIAL DUTY							
DATE	PLACE	PURPOSE	RESULT-RECOMMENDATION (Defects-Waivers)	BUMED ACTION	SIG. OF M. O.		
15 SEP 82	SubBase NlonConn	ApplSub Train	Physically qualified. (Defect. vision) O.U. 20/40; corr. 20/20 NCD.		<i>J.R. Smith</i> LT MC USN		
21 MAY 82	USN DivScolNGF Wash DC	ApplDiv Train	Physically qualified. (Defect. vision) O.U. 20/30; corr. 20/20 NCD.		<i>W.T. Hatch</i> CAPT MC USN		
35 JUN 83	USN DivScolNGF Wash DC	Re-qualif & Waiver	Physically qualified for continuance DivDuty. Waiver granted - BUPERS for max age std 1 JUN 83		<i>W.T. Hatch</i> CAPT MC USN		
Appropriate entry of qualification or disqualification shall be made at the time of each examination.							
77 AUG 82	USS CARRIER CV-00	Special	Physically qualified and aeronautically adapted for duty invol the actual con- trol of aircraft. Service Group I	Appvd. 21 AUG 82	<i>J.R. Smith</i> LCDR MC USN		
SUSPENSION FROM SPECIAL DUTY							
DATE (From)	(To)	NO. OF DAYS	REASON FOR SUSPENSION	SIGNATURE OF MEDICAL OFFICER			
17 JAN 82	9 JAN 82	3	Common Cold	<i>A.B. Seay</i> LT A. B. SEAY MC USN			
21 Nov 82	10 NOV 82	10	Influenza	<i>W.T. Hatch</i> CDR W.T. HATCH MC USN			
PERIODIC SPECIAL DUTY REQUALIFICATION							
DATE	SIG. OF M. O.	DATE	SIG. OF M. O.	DATE	SIG. OF M. O.		
10 JAN 82	<i>J.J. White</i>	7.	Include any enlisted special duty design- ation.	13.	Indicate USN or USMC status		
11 NOV 82	<i>J.J. White</i>	8.		14.		Enter date of birth.	
11 NOV 82	<i>J.J. White</i>	9.		15.			
		10.		16.			
		11.		17.			
		12.		18.			
NAME	(Last)	(First)	(Middle)	GRADE/RATE	SERVICE/SEC. SEC. NO.	ORGANIZATION	AGE

Illustration 7. NAVJED 6150/2, Special Duty Medical Abstract (Front)

ALTITUDE TRAINING, AIR COMPRESSION AND OXYGEN TOLERANCE			
DATE	STATION	TYPE OF RUN-REACTION	
1. 27 MAR 81	NAS Cecil Field	Indoctrination	M.A. Brown M.A. BROWN LT MSC USN
2. 1 APR 81	NAS NORVA	Pressure Breathing	B.R. Hunter CDR MSC USN
3. 15 APR 81	NAS Miramar	Full Pressure Suit	B.E. Cloud LCDR MSC USN
4.			
5.			
EXPLOSIVE DECOMPRESSION TRAINING			
DATE	STATION	ALTITUDES-REACTION	
1. 25 JAN 82	NAMI Pensacola	(24,000-66,000 meters) 8000-22,000 ft	D.G. Morris CDR MSC USN
2. 2 Feb 82	NAS Miramar	(90,000-150,000 meters) 30,000-50,000 ft	B.E. Cloud LCDR MSC USN
SUBMARINE ESCAPE AND DIVING TRAINING			
DATE	STATION	TYPE OF RUN-REACTION	
1. 25 JAN 83	NAS NORVA	Water Survival Training	B.R. Hunter CDR MSC USN
2.			
3.			
4.			
5.			
VISUAL AND DISORIENTATION TRAINING			
DATE	STATION	TYPE OF TRAINING	
1. 2 JUN 82	MCAS Beaufort	Visual Problems with (without) demonstrations V S F	P.L. Pratt LTJG MSC USN
2.			
3.			
4.			
CENTRIFUGE AND EJECTION SEAT TRAINING			
DATE	STATION	TYPE OF RUN-REACTIONS	
1. 2 APR 82	NAVHOSP Whidbey Island	Ejection Seat Indoctrination	P.T. Hart LT MSC USN
2. 2 APR 83	NAS Cecil Field	Ejection Seat Refresher	M.A. Brown LT MSC USN
REMARKS:			

Illustration 7A. NAVMED 6150/2, Special Duty Medical Abstract (Back)

(See article 16-47 for details.)

HEALTH RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE														
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)															
1 MAY 81	RETAIN PERMANENTLY IN HEALTH RECORD															
NAVAL HOSPITAL, BLANK, VIRGINIA																
CHANNEL NUMBER	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
INTERPRETATION	A	A	A	A	A	C	C	C		C						
AND	T	T	T	T	R	L	L	L		A						
SEQUENTIAL NUMBER	A	B	AB	D	R	A	B	O	CDE	O						

O POS

000031

CHANNEL NUMBER	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	FOR ABO GROUP REFER TO CHANNELS 1,2, AND 3. IF AGGLUTINATION IS IN 1 AND 3, INDIVIDUAL IS GROUP A. IF AGGLUTINATION IS IN 1,2 AND 3, INDIVIDUAL IS GROUP AB. IF AGGLUTINATION IS IN 2 AND 3, INDIVIDUAL IS GROUP B. IF NO AGGLUTINATION IS IN 1,2, AND 3, INDIVIDUAL IS GROUP O.														
	FOR Rh TYPE REFER TO CHANNEL 4. IF AGGLUTINATION IS IN 4, INDIVIDUAL IS Rh ₀ (D) POSITIVE. IF NO AGGLUTINATION IS IN 4, INDIVIDUAL IS Rh ₀ (D) NEGATIVE.														
	FOR STS. REFER TO CHANNEL 5. IF PRECIPITATION IS IN 5, INDIVIDUAL IS REACTIVE. IF NO PRECIPITATION IS IN 5, INDIVIDUAL IS NON-REACTIVE.														
	TO CONFIRM BLOOD GROUP REFER TO CHANNELS 6 AND 7. IF AGGLUTINATION IS IN 6, INDIVIDUAL IS GROUP B. IF AGGLUTINATION IS IN 7, INDIVIDUAL IS GROUP A. IF AGGLUTINATION IS IN 6 AND 7, INDIVIDUAL IS GROUP O. IF NO AGGLUTINATION IS IN 6 AND 7, INDIVIDUAL IS GROUP AB.														
	CHANNEL 8 IS USED FOR ANTIBODY DETECTION. IF AGGLUTINATION IS PRESENT FURTHER BLOOD STUDIES ARE INDICATED. SEE REMARKS BELOW.														
	CHANNEL 9 IS USED FOR C AND E FACTORS, AND TO CONFIRM AGGLUTINATION IN CHANNEL 4. NOTE: CHANNEL 9 MAY BE POSITIVE AND CHANNEL 4 NEGATIVE IF INDIVIDUAL IS C OR E POSITIVE. SUCH PERSONS ARE Rh NEGATIVE AS RECIPIENTS BUT ARE CONSIDERED Rh POSITIVE AS DONORS.														
	CHANNELS 11-15 ARE RESERVED FOR SPECIAL STUDIES IN BLOOD CENTERS														

REMARKS

Sickle Cell - Positive 38% HbS
G-6-PD - Negative

EXAMPLE
OF
PROCESSING
NUMBER

NOTE THAT
THIS PORTION
MATCHES SEQUENTIAL
NUMBER ABOVE

112031

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

PATIENT'S NAME (Last, First, Middle initial)

DOE, John J.

SEX
MYEAR OF BIRTH
9 MAY 60

RELATIONSHIP TO SPONSOR

COMPONENT/STATUS
ADDEPART/SERVICE
USN

SPONSOR'S NAME

RANK/GRADE
SR

SSAN OR IDENTIFICATION NO.

987-65-4321

ORGANIZATION

NAVSTA Blank, VA

SPECIAL - BLOOD GROUPING AND TYPING RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

Standard Form 600
600 106

Illustration 8. Standard Form 600, Special-Blood Grouping and Typing Record

Chapter 17

DEATHS

Sections

	Articles
I. General	17-1 through 17-2
II. Certificate of Death	17-3 through 17-6

Section I. GENERAL

	Article
Decedent Affairs Manual.....	17-1
Autopsies.....	17-2

17-1. Decedent Affairs Manual

(1) NAVMEDCOMINST 5360.1 series, Decedent Affairs Manual, implements the Navy's Decedent Affairs Program, which consists of all activities relating to the search for, recovery, identification, care, and disposition of the remains of deceased persons for whom the Department of the Navy is responsible.

(2) This chapter consists of matters relating to deaths not considered appropriate for inclusion in the NAVMEDCOM Instruction.

17-2. Autopsies

(1) Deceased Military Personnel.—When deemed necessary by (a) the member's commanding officer, (b) an investigating officer, (c) other fact-finding body, or (d) a medical officer, to determine the true cause of death, to secure information for the completion of military records, or to protect the welfare of the military community, an autopsy (NAVMED P-5065, Autopsy Manual) will be performed on the remains of any person who dies in the military service while serving on active duty or active duty for training. When death occurs while serving as an aircrew member of a military aircraft, the medical officer will recommend to the commanding officer having custody of the remains that an autopsy be performed to determine the cause of death. Under these circumstances, the commanding officer may authorize such an autopsy. The "cause of death" in this connection is interpreted to mean any correlation between pathological evidence and the accident cause factors.

(2) Other Deceased Persons.—When an autopsy is deemed necessary for retired personnel or nonmilitary persons who die in a naval medical treatment facility or at a Navy installation, obtain written authorization

from the primary next of kin before performing an autopsy. Authorization will normally be obtained on an SF 523, Authorization for Autopsy. When the authorization is obtained by letter, telegram, or voice-recorded or monitored telephone call, medical facility authorities will complete an SF 523 and attach the letter, telegram, voice-recording, or memorandum confirming the telephone call of authorization. If permission is unobtainable, and an autopsy is required to complete records of death in compliance with local, State, or Federal law, make a report to civil authorities for necessary action.

(3) Authorization for Autopsy.—When an autopsy is authorized by a member's commanding officer, and in other instances in which authorization from proper authority has been obtained, the appointed investigating officer, or other fact-finding body, will provide the medical officer designated to conduct the autopsy with a detailed preliminary report of circumstances surrounding the death. (When the authorization for autopsy has been granted by other than the commanding officer, the medical officer will advise the command authority that authorization has been granted.) Upon completion, the medical officer conducting the autopsy will provide the investigating officer, or other fact-finding body, with a copy of the preliminary autopsy findings as to the cause of death and, when completed, a copy of the final protocol. The investigating officer, or other fact-finding body, will provide the medical officer conducting the autopsy with a copy of the final investigation report. Record autopsies on Standard Form 503, Autopsy Protocol.

(4) Autopsy Manual.—Perform autopsies (NAVMED P-5065, Autopsy Manual) promptly and with a minimum of disfigurement. The expeditious release of remains for preparation, encasement, and shipment to the primary next of kin is very important.

1000



Section II. CERTIFICATE OF DEATH

	Article
General Requirements	17-3
Type of Certificate	17-4
Copy Distribution	17-5
Cost of Civil Certificates of Death	17-6

17-3. General Requirements

(1) Active Duty.—For deaths of active duty Navy and Marine Corps personnel and Navy and Marine Corps Reserve personnel serving in an active-duty-for-training or inactive-duty-training status as defined in MILPERSMAN or the Marine Corps Reserve Standard Operating Procedure (P1001R.43), as appropriate, a certificate of death will be processed by the Medical Department of the command to which the member was attached. If the member was on detached duty, awaiting orders, or on leave or liberty, the Medical Department representative of the naval region or fleet where the individual died will process the certificate of death as detailed in article 17-5.

(2) Inactive Duty.—Any Navy or Marine Corps activity that receives information, regardless of the source, concerning the death of a Navy or Marine Corps Reserve, Fleet Reserve, Fleet Marine Corps Reserve, or retired member of the naval service not on active duty will determine the identity of the decedent, service affiliation, permanent home address, and date, place, and cause of death. Additionally, when informed of such a death, procure a copy of the civil certificate of death to use in closing the service and health records.

(3) Other Deaths.—For all other deaths (dependents, other civilian personnel, and military other than those indicated above) occurring at a naval activity, on board a naval ship, or on a naval aircraft, a certificate of death (preferably civil) will be processed by the Medical Department representative responsible for providing medical care to the activity. This requirement also applies to fetal deaths. (Fetal death is death occurring prior to the complete expulsion or extraction from the mother of a product of conception of 20 weeks or more gestation, or fetal weight of 500 grams or more; the death is indicated by the fact that after such separation, the fetus does not breathe nor show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.) Make reports of death of U.S. citizens (other than members of U.S. Armed Forces), who die in foreign countries, to nearest U.S. consular office.

(4) Missing Persons.—Do not prepare a certificate of death if an individual is reported as "missing." However, the follow-

ing is applicable when an administrative determination of death has been made by naval sources on individuals "missing" outside the 50 United States and the District of Columbia or along the coastline of those States that will not issue a death certificate in the absence of a body:

(a) Active Duty Members.—The activity holding the member's Health Record will prepare A DD Form 2064. The Health Record will then be closed and forwarded following guidance in article 16-12(3). (Also see article 17-5(2).)

(b) Naval Civilian Employees.—

(1) Military Sealift Command (MSC) Employees.—MSC Headquarters, Washington, DC will prepare a DD Form 2064.

17-4. Type of Certificate

(1) Deaths Occurring Within the 50 United States and the District of Columbia.—A civil certificate of death.

(2) Deaths Occurring Outside the 50 United States and the District of Columbia.—DD 2064, Certificate of Death (Overseas), as applicable, in addition to the civil certificate of death if required by local civil authorities.

17-5. Copy Distribution

(1) Deaths in the 50 United States and the District of Columbia.—Follow local civil requirements for the processing of civil certificates of death. Additionally, provide copies (quick copy or "work sheet" copy is acceptable) of the civil certificate of death with the deceased member's social security number added in upper right margin, to the following:

(a) Active Duty.—

(1) One Copy with closed Health Record per article 16-12.

(2) One copy to Commanding Officer, Naval Medical Data Services Center, Bethesda, MD 20014.

(b) Inactive Duty.—

(1) For naval reservists, fleet reservists, and retired members of the Navy and Naval Reserve — one copy to the Naval Reserve Personnel Center, 4400 Dauphine Street, New Orleans, LA 70149.

(2) For marines, marine reservists, fleet reservists, and retired marines — one copy to Commandant of the Marine Corps,

Code MSPA-1, Navy Department, Washington, DC 20380.

(3) For deaths occurring at a naval activity, on board a naval ship, or on a naval aircraft - one copy to Commanding Officer, Naval Medical Data Services Center, Bethesda, MD 20014.

Custodial responsibility for health records of Navy and Marine Corps Reserve members not on active duty is set forth in chapter 16 of this manual.

(c) Other Deaths as Specified in Article 17-3(3).-

(1) Follow local civil requirements (NAVMEDCOMINST 5360.1 series refers).

(2) One copy to Commanding Officer, Naval Medical Data Services Center, Bethesda, MD 20014.

(2) Deaths Outside the 50 United States and the District of Columbia.-Follow local civil requirements for the processing of civil certificates of death. Additionally, for the categories indicated, prepare DD 2064, Certificate of Death (Overseas), and provide copies to the following:

(a) Active Duty.-

(1) Original with closed Health Record following article 16-12.

(2) One copy to Commanding Officer, Naval Medical Data Services Center, Bethesda, MD 20014.

(b) Inactive Duty.-Same as articles 17-5(1)(b)(1), (2), and (3).

(c) Other Deaths.-One copy to activity indicated for following persons if death occurred at a naval activity, on board a naval ship, or on a naval aircraft.

(1) Army Members.-

(a) Office of the Adjutant General, U.S. Army, DAAG-PEC, Washington, DC 20314.

(b) Commanding Officer, Naval Medical Data Services Center, Bethesda, MD 20014.

(2) Air Force Members.-

(a) Office of the Surgeon General, Department of the Air Force, Bolling Air Force Base, Washington, DC 20332.

(b) Commanding Officer, Naval Medical Data Services Center, Bethesda, MD 20014.

(3) Coast Guard Members.-

(a) Commandant, U.S. Coast Guard, G-PS-1/TP 56, Washington, DC 20593.

(b) Commanding Officer, Naval Medical Data Services Center, Bethesda, MD 20014.

(4) Veterans Administration Beneficiaries.-

(a) Local regional office of the VA that authorized patient's admission.

(b) Commanding Officer, Naval Medical Data Services Center, Bethesda, MD 20014.

(5) Dependents, Navy Civilian Employees, and Other Civilians.-

(a) Original to Commander, Naval Medical Command, MEDCOM-332, Washington, DC 20372-5120.

(b) Commanding Officer, Naval Medical Data Services Center, Bethesda, MD 20014.

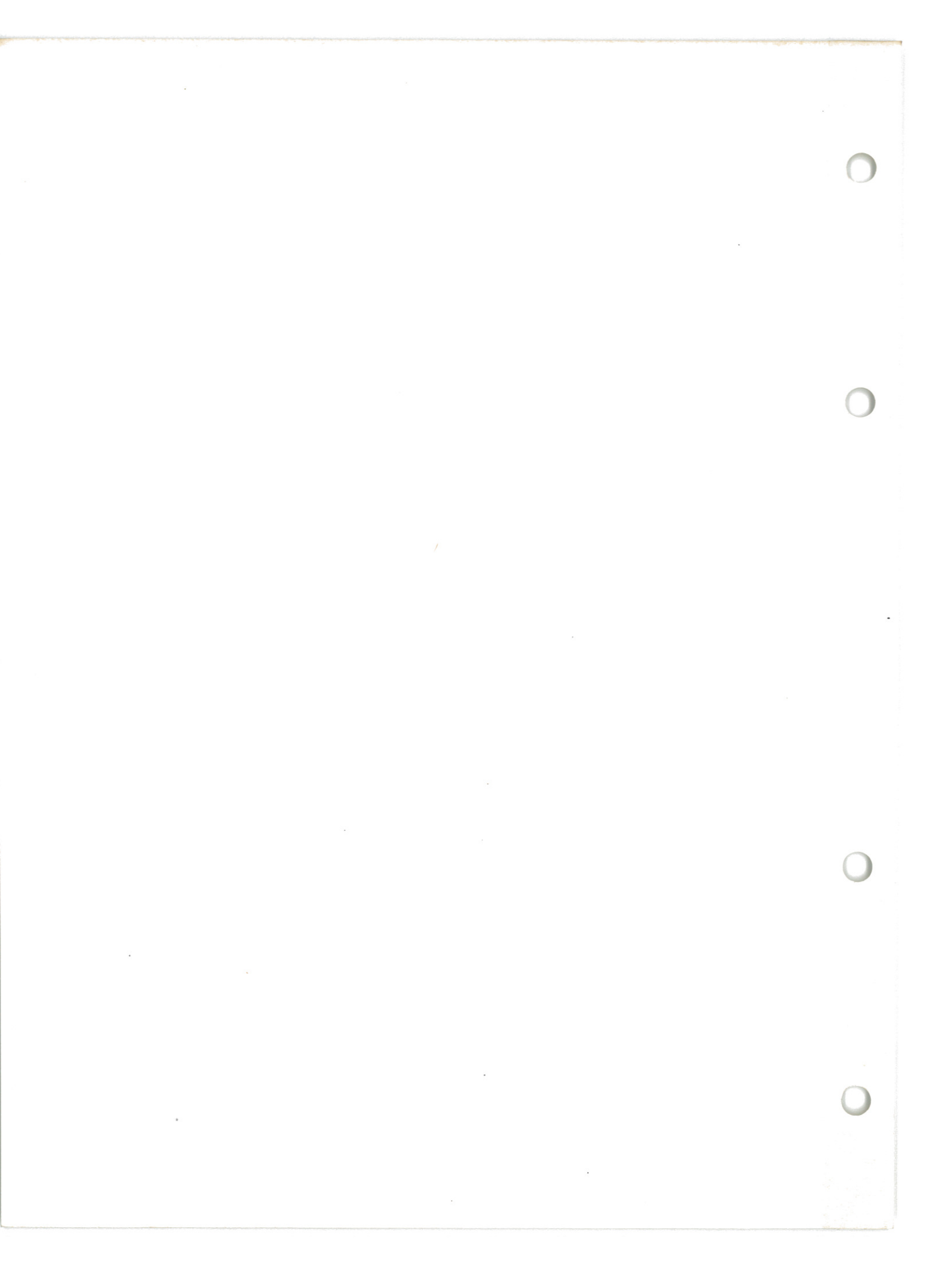
(3) Transportation Copies.- In each instance, see NAVMEDCOMINST 5360.1 series, Decedent Affairs Manual, regarding copies required for transportation of remains.

17-6. Cost of Civil Certificates of Death

(1) If a quick copy or "work sheet" copy of the civil certificate of death is not obtainable and a free copy is not provided by the State or city, the cost of each necessary copy is chargeable to the following appropriation:

(a) 17*1804.188M 000 00018 M 000179 2D LNT000 990030000LNT.

(b) Enter applicable Fiscal Year in space for third digit (*); e.g., 7=FY 1987 and 8=FY 1988.



Chapter 18

MEDICAL DISPOSITION

Sections

	Articles
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III. Medical Board	18-7 through 18-33

Section I. RECRUIT EVALUATION UNIT

	Article
Recruit Evaluation Unit	18-1
Fitness of Recruits for Service, Determination of	18-2

18-1. Recruit Evaluation Unit

(1) Commanding officers of naval medical facilities having primary responsibility for medical support of recruit training centers or recruit depots will establish a recruit evaluation unit (REU) as a branch of the psychiatric department. The REU is a professional, advisory, and consultant unit to which recruits with possible mental health problems are to be referred for appropriate mental health examinations. The REU and the medical clinic serving the recruit command are responsible for identifying physical or mental defects which may impair or incapacitate a recruit's ability to benefit from training or become functional in full service. Defects or functional disturbances which existed prior to enlistment, such as mental illness or inadequacy, emotional immaturity or other personality defects, lack of stamina, enuresis, and somnambulism, among others, are to be given careful consideration for interference to ability to perform assigned duties.

(2) The commanding officer of the supporting medical facility has the responsibility for organization and general supervision of the REU. This includes arrangements for appropriate equipment and space for the administrative functions of the unit, as well as sufficient space to ensure the conduct of examinations in such a manner that conversations between the examiner and the examinee are not overheard. The medical facility will put at the disposal of the REU sufficient bed space for the proper observation and care of recruits who need these services.

(3) Functions of Members of the REU.-

(a) The psychiatrist or clinical psychologist assigned as head of the REU will be responsible for conducting the mental

health examinations and is also responsible for the work of other members of the unit. Decisions within the unit will be made by the branch head, however, further referral of reports for disposition will be based upon his or her recommendation and will be subject to the approval of the head of the psychiatric department of the medical facility.

(b) Hospital Corps members assigned to the unit will perform the duties necessary for maintenance of the outpatient functions, keep the records, and obtain data pertaining to life histories of recruits under consideration by the unit.

(4) Mental Health Examinations.-

(a) When practicable, an REU psychiatrist or clinical psychologist will render a brief examination to each recruit as part of the initial examination. To restrict interference with routine procedures to which incoming recruits are subjected, examiners may schedule and conduct more extensive examinations at a later date when such examinations are indicated. After initial examinations, recruits may be referred, through the normal chain of command, to the REU at any time during the training period by company commanders, drill instructors, division officers, or branch clinic personnel.

(b) After an examination at any time during the training period, a recruit with obvious and serious handicaps will be sent, pending further disposition, to the psychiatric service of the medical facility. Recruits with less obvious or less serious handicaps, or those about whose fitness for service there is doubt, will be returned to a trial of duty and observed under drill and training conditions in a regular recruit company with the understanding that the REU examiner will have the opportunity for further examination if deemed necessary.

18-2. Fitness of Recruits for Service, Determination of

(1) The evaluation of each recruit's fitness for service is a necessary function of the activities which serve as centers for training of recruits. This evaluation process will be conducted with a view to separating from service those personnel determined not suited for military service because they cannot be expected to perform useful duty. To this end, every reasonable effort will be made to detect those recruits who present defects or tendencies which were concealed or not detected at the time of enlistment or induction. Whereas the evaluation of each recruit's psychological fitness is determined by the REU, the preliminary evaluation of physical fitness will be conducted by the Medical Department personnel assigned to the medical entity serving the recruit command.

(a) To develop a data base to assist in the study of recruit attrition, each Medical Department facility providing treatment to recruits on a routine basis will maintain a record system that will provide a ready source of information concerning:

(1) Identification of recruits requesting care.

(2) If defects are detected that warrant release of a recruit, medical reason for failure to complete recruit training.

(3) Whether the problem, for which the recruit is requesting care, existed prior to entrance (EPTC).

(4) Whether the problem was caused or exacerbated by the training.

(5) Whether the recruit knew of the problem prior to recruitment.

(6) Whether the recruit tried to conceal the problem.

(7) Whether the recruiter may have encouraged this concealment.

(8) Name and district of the recruiter.

(9) Number of recruit failures by month.

(b) The 9 items of information above will be maintained at treatment facilities and will be monitored by geographical naval medical commands (GEOCOMs). If significant problems occur repeatedly at any facility, regional commands should forward a letter report to COMNAVMEDCOM (MEDCOM-25) requesting assistance in the coordination of corrective action with:

(1) The Commander, Navy Recruiting Command and Commander, Military Entrance Processing Station (MEPS) for Navy members.

(2) The Commandant of the Marine Corps (Code MRRE) for Marine Corps members.

(3) A recruit will be processed for separation because of physical or mental defect when unable to perform the duties of the rate in such a manner as to reasonably ful-

fill the purpose of the member's employment on the active list. Company commanders, drill instructors, division officers, or other cognizant personnel may assist greatly by referring for medical attention those recruits who are not adjusting well to training conditions. A recruit manifesting severe emotional disabilities such as a psychotic episode, may be referred for separation via a medical board after an adequate period of observation and indicated treatment. When appropriate, recruits who are to be separated should be transferred to the Veterans Administration hospital nearest their home for appropriate hospitalization and reintegration into the community. (Note: The Veterans Administration may not accept all such recruits due to their limited time in service.)

(3) Recruits found to have a physical condition or defect which, had it been known at the time of entry, would have been considered disqualifying for enlistment are subject to referral for administrative discharge processing by reason of defective enlistment (erroneous enlistment).

(a) Conditions or defects not considered to be a physical disability as defined in SECNAVINST 1850.4 series normally do not require an evaluation by a medical board. Medical certification in the Health Record with an established diagnosis is sufficient. These conditions include somnambulism, enuresis, personality disorder, motion or air sickness, allergies, excessive weight, and obesity or weight control among others.

(b) Conditions or defects considered to be a physical disability are referred to a medical board for evaluation.

(c) Minor physical conditions or defects described in this article need not be reason for separation when considered not to interfere with training and not expected to interfere with the recruit's ability to perform full duties. An evaluation of these minor conditions is to be recorded on an SF 600 with the recommendation for continued service. No further action is required unless the recruit experiences interference during training.

(d) Physical conditions or defects discovered during recruit training should be evaluated with ample consideration for the recruit's ability to adjust to military service and demonstration of capability to perform and function effectively when transferred to full service. Questionable cases may be determined by a trial period of duty in the regular recruit training schedule.

(4) Recruits incurring an illness or injury while on active duty or incurring an aggravation to a condition that existed prior to entry on active duty will be referred to a medical board when that condition may interfere with ability to benefit from training or with performing assigned duties when transferred to full service.

Section III. Medical Board

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18-7. Purpose

(1) Medical boards serve to report upon the present state of health of any member of the Armed Forces and as an administrative board by which the convening authority or higher authority obtains a considered clinical opinion regarding the physical status of service personnel.

(2) Members of the medical board are cautioned against use of the term "unfit" in the context of the medical board as that determination may only be made by the Naval Council of Personnel Boards upon review. Use of the term "unfit" leads to confusion on the part of patients and other personnel unfamiliar with the Disability Evaluation System.

18-8. Composition

(1) The senior member of a medical board will be a Medical Corps officer of the Armed Forces or Public Health Service except in those instances when the basis for the board is a matter within the discipline of dental treatment. In the latter instance, it is preferable that the senior member be a Dental Corps officer, however, the other primary member must be a Medical Corps officer.

(2) Except as indicated in (1) above and (6), (7), and (8) below, medical boards will be composed of two Medical Corps officers of the Armed Forces or Public Health Service. A third member may be assigned at the dis-

cretion of the convening authority. At those activities employing civilian doctors of medicine, osteopathy, or dentistry, the convening authority may authorize not more than one civilian doctor to be assigned as the third member of a medical board.

(3) One of the medical board members should be a senior officer with detailed knowledge of the directives pertaining to standards of medical fitness and unfitness, disposition of patients, and disability evaluation procedures. Whenever possible, the medical board will be composed of the appropriate department head (or designated representative) and the medical or dental officer responsible for the patient's care. Other medical or dental officers or civilian doctors of medicine, osteopathy, or dentistry employed by the Navy Department may be assigned as the convening authority directs.

(4) When neither member of the medical board has training in the specialty of the patient's primary impairment, obtain appropriate specialty consultations prior to preparation of the report by the medical board.

(5) When the party before the board is a reservist, the membership of the board will include Reserve representation. In any instance where Reserve members are not available, the convening authority will so indicate in the forwarding endorsement.

(6) In situations where the findings are that the individual is mentally incapable of managing personal and financial affairs, the medical board will consist of three medical

officers or physicians, at least one of whom will be a psychiatrist (37 USC 602 and chap 15, JAGMAN refer). The psychiatrist will be designated on the medical board with (P) after his or her name.

(7) In situations where mental incompetence is to be determined under Rules for Court Martial (R.C.M.) 706(c)1, the medical board will consist of three members. Each member of the board must be either a physician or clinical psychologist. At least one member must be either a psychiatrist or clinical psychologist.

(8) A psychologist who has participated in a member's evaluation may sign such report as the third member except as set forth in subarticle (6) above. The psychologist member will be designated on the medical board with (CP) after his or her name.

18-9. Convening Authority

(1) Commanders of regional medical commands, commanding officers of all naval hospitals, and the commanding officer of the Naval Medical Clinic, Pearl Harbor may convene a medical board upon any member of the Armed Forces. Medical boards may also be ordered by the CNO, CINCs, CMC, COMNAV MILPERSCOM, and the Commander, Naval Medical Command (COMNAVMEDCOM), Washington DC.

(2) A convening authority may delegate, in writing, signatory responsibility for approving/disapproving recommendations and findings of board members (completing item 24 of the Medical Board Report Cover Sheet, NAVMED 6100/1). Delegation may not be granted below the directorate level in a hospital command or below the level of the commanding officer or officer in charge at a branch clinic.

18-10. Guidance for Medical Board Preparation

(1) Although medical and dental officers do not determine physical unfitness for service, they should be familiar with the basic policies and concepts to be able to carry out the responsibility for identifying members whose physical fitness for full duty may be in doubt. There is no provision or authority for waiving a defect that would interfere with a member's ability to reasonably perform the duties of his or her grade or rate. It is not possible to list and define all the medical factors that may compromise a member's ability to reasonably perform the duties of his or her grade or rate; however, SECNAVINST 1850.3 series provides certain guidelines on conditions which normally render an individual unfit because of physical disability. Refer to this instruction in questionable situations. On the other hand, there is no substitute for competent and mature military

medical judgment in appraising all relevant factors in a given report.

(2) The mere presence of a physical defect does not in itself automatically require or justify referring a medical board to a PEB. The test must always be whether the defect interferes with the member's reasonable performance of assigned duties. Initial enlistment and commissioning physical standards must not be confused with physical capability to perform duty. Once enlisted or commissioned, the fact that a member may later fall below initial entry standards does not require that the report be referred to a PEB. Similarly, there are prescribed minimum physical standards for special duties such as flying. Disqualification for special duties does not necessarily imply physical unfitness unless the disqualifying defect would also interfere with the performance of other duties. Medical board evaluation is appropriate only in instances where the member's ability to reasonably perform military service is in doubt.

(3) Information contained in medical boards may play an important role in determining the rights of an individual to certain benefits (such as pensions, compensation, promotion, retirement, income tax exemptions, etc.). It is therefore essential to include in the report all available information with adequate documentation concerning the origin, nature, aggravation by service, and other significant facts concerning all the member's conditions.

(a) To guarantee all members' right to separation under the proper provisions of law, members who expect to be separated from the service by medical board action may request that COMNAV MILPERSCOM or CMC, as appropriate, amend or stop the medical board process to allow the member to be separated under another more appropriate provision of law. Such requests may be honored only if received before the final decision of the board is released.

(b) Medical Department personnel will assist members with their requests, rebuttals, or submission of new information. When boards have been endorsed by the convening authority and forwarded for further action, send requests, rebuttals, or submission of new information to the addressee listed in item 1 of the NAVMED 6100/1, Medical Board Report Cover Sheet, via the convening authority.

18-11. Referral to a Medical Board

(1) Members serving under orders to active duty for 30 days or longer who are returned to full duty with limitation and those who require transfer to another Armed Forces hospital prior to final disposition should ordinarily be considered by a medical board prior to such disposition.

(2) A medical board is mandatory when:

(a) A member is temporarily unable to perform full duty but return to full duty is anticipated and it is desired to follow the patient for a short period of time before final disposition is made, i.e., "limited duty."

(b) A member refuses reasonable medical, dental, or surgical treatment and the member's ability to perform full duty is suspect.

(c) A member's condition requires referral to PEB for a determination of fitness for duty.

(d) Continued military service would probably result in an inordinate amount of hospitalization or other close medical supervision; or would be likely to aggravate the existing condition.

(e) A member's condition includes the presence of mental incompetency or incapability to manage personal or financial affairs.

(f) A member's condition is such as to require permanent assignment limitations; i.e., specific geographic assignment, etc.

(g) In the opinion of the cognizant medical officer a service member has suffered from a significant illness or injury which may impact on future service, even though the member may now appear to be fit for full duty.

(3) A medical board is also mandatory when a member of the Naval Reserve or Marine Corps Reserve contracts disease or becomes ill in line of duty while on active duty or performing inactive duty training specified as 30 days or less, if the member requires hospitalization, transportation, and subsistence which may extend beyond 10 weeks after the member is released from active duty. (See NAVMEDCOMINST 6320.3 series.)

(a) Such medical boards will not be submitted to the Central Physical Evaluation Board. They will instead be submitted to the Commander, Naval Reserve Forces or Commandant of the Marine Corps, as appropriate, via COMNAVMEDCOM (MEDCOM-25). A copy of the report will be provided to the member's parent Reserve unit.

(b) Because there is no "limited duty" status for inactive Reserve members, the provisions of articles 18-19 and 18-20 are not applicable to such members. Inactive reservists who have achieved the maximum benefit of immediate active medical care, but require an additional period of rehabilitation or observation to determine the extent of recovery or who may require additional treatment at a later time, will be so identified in the narrative summary of the report. Also include in the board report the medically recommended period of rehabilitation or observation, or estimated date of future additional care.

(c) The differing administrative features of inactive Reserve duty status and entitlement to Reserve disability pay require

an expressed medical opinion as to whether there is a medical recommendation to substantially curtail routine activities during any intervening period between active medical care and the completion of either rehabilitation, observation, or treatment required to return the reservist to a full duty status. In providing medical opinions, physicians will restrict their remarks to military associated duties. However, it is appropriate to include a separate recommendation concerning the member's ability to perform civilian employment (e.g., no heavy lifting for a member whose civilian employment is as a bricklayer).

(d) As required for other boards, a copy of the line of duty investigation report will accompany the medical board report submitted for departmental review. An explanation of the circumstances for nonsubmission will be included in the narrative with appropriate notation on the Medical Board Report Cover Sheet (NAVMED 6100/1).

(4) Articles 18-12 through 18-21 provide further guidance concerning these and various other categories of personnel situations where referral to a medical board may be appropriate or is required.

(5) Unless otherwise indicated, a member need not be admitted to the sicklist to appear before a medical board.

(6) The situations enumerated in (2) above are equally applicable to members of all military services, including the U.S. Coast Guard. Accordingly, medical boards will be conducted upon any such member when requested by appropriate authorities of the member's service (see article 18-33 on U.S. Coast Guard members).

18-12. Officers

(1) When an officer is to be returned to duty after undergoing treatment for a severe or possibly incapacitating condition, particularly when it may affect the officer's reasonable performance of duty during further convalescence, the officer will be referred to a medical board before being returned to duty. Further, whenever a condition is detected that may adversely affect the officer's selection for promotion, appearance before a medical board is appropriate.

(2) When an officer candidate or midshipman has been undergoing treatment for any impairment which is likely to be recurrent or progressive or to become incapacitating either prior or subsequent to appointment, the officer candidate or midshipman will be ordered before a medical board before being returned to duty. The physical fitness of such members is to be evaluated in regard to probable ability to perform duty in commissioned grade rather than to continue in training. In such instances, final determination of the member's physical fitness

for appointment to commissioned grade will be held in abeyance pending Departmental action on the board's report.

(3) When an officer is hospitalized as a result of a defect or disability noted in the officer's triennial or annual physical examination, the officer will be referred to a medical board prior to being returned to duty.

(4) Whenever, following instructions in the preceding subarticles, it is determined that a class 1 or class 2 aviation officer is to appear before a medical board that will recommend return to full duty, a flight surgeon should be assigned as a member of the medical board. A complete aviation physical examination will be conducted by a flight surgeon and reported on an SF 88. A flight physical examination is not required when a medical board is held incident to an officer's pending separation from the active list or when the indicated disposition is to limited duty or referral to the Central Physical Evaluation Board. It is the responsibility of the convening authority of the medical board to submit the medical board report to COMNAVMEDCOM (MEDCOM-25). In addition, in every case involving a class 1 or 2 aviation officer, a copy of the board report, along with the original flight physical examination if required, will be submitted to the Naval Aerospace Medical Institute (NAMI), Naval Air Station, Pensacola, FL 32508 (NAMI-14). When found fit for duty, the officer may be discharged from the sicklist to await Departmental review on the board's report and the physical examination.

(5) When an officer of the Navy or the Marine Corps (Regular or Reserve) on active duty with less than 3 years continuous service as an officer is considered physically disabled by reason of a condition which was incurred while the officer was not in receipt of basic pay, and which has not been aggravated by a period of active service, the officer will be ordered before a medical board. Should the medical board recommend the officer's separation by reason of physical disability which was incurred while the officer was not in receipt of basic pay and was not aggravated by service, the officer will be advised of the rights to a full and fair hearing before a PEB. If the officer does not desire to waive these rights to a full and fair hearing, then the medical board report will be referred to the Central PEB. Should the officer waive the rights to a full and fair hearing, the officer will certify in writing on NAVMED 6100/3, that such a hearing is not demanded. The medical board report with the NAVMED 6100/3 will be forwarded to COMNAVMEDCOM (MEDCOM-25).

(6) Officers of the Navy or the Marine Corps (Regular or Reserve) on active duty with more than 3 years continuous service as

an officer who are considered to be disabled by reason of a physical disability will be referred to a medical board with subsequent referral to the Central PEB.

18-13. Medical Board with Discipline or Administrative Involuntary Separation Action Pending

(1) When a medical board report is considered necessary and (a) courts-martial or investigation proceedings are pending, indicated, or have been completed or (b) in situations of uncompleted sentences of courts-martial involving confinement where the disciplinary features of the medical board warrant resolution prior to or in connection with further disposition, the medical board report, with all pertinent facts relative to the disciplinary aspects of the situation, will be submitted for Departmental review. Orders directing disposition or authorizing the appearance of the member before a PEB will not be issued by the convening authority. The collection of pertinent facts relating to the disciplinary features in such situations is not a function of the medical board. This will be accomplished by the commanding officer of the command to which the member was attached prior to hospitalization.

(2) Members who have received an administrative discharge under MILPERSMAN articles 3630100 through 3630900 or a punitive discharge, without confinement, will not be afforded medical board action as these discharges take precedence over medical disability separations or limited duty considerations. In such instances, completion of the SF 88 or SF 93, with physical defects noted, will be accomplished and made a permanent part of the member's Health Record.

(3) If a member becomes subject to disciplinary action or is awarded a punitive discharge or involuntary administrative separation after the medical board has been submitted, immediately notify COMNAVMILPERS COM or MARCORPS, as appropriate, by message.

(4) As an exception to paragraphs (1) and (2), a medical board will be submitted for Departmental review on all members having psychiatric disorders when there is a question of mental incompetency, regardless of discharge action or pending discharge recommendations.

18-13A. Conditions Not Considered a Physical Disability

(1) SECNAVINST 1850.4 series directs disposition of members with conditions not considered a physical disability. NAVMILPERS COMINST's 1910.1 and 1910.2 series, and MCO

P1900.16 series apply. A medical board is neither required nor desired in such cases. A report of the medical findings surrounding the member's condition will be submitted to the member's parent command identifying the defect, with a medical evaluation of any severity which may impair the member's ability to function effectively in the naval service.

18-14. Mental Competency/Incapacitation Evaluation

(1) Mental Competency.-

(a) A medical board will be convened when a member demonstrates impairment of judgment secondary to psychiatric disorder(s) (excluding personality disorders) or other condition(s) especially if (1) the question of impaired judgment is raised incident to a pending trial, (2) administrative involuntary separation is indicated or is being processed, (3) an investigation has been or will be conducted pursuant to chapter 8 JAG Manual, or (4) it is anticipated that disciplinary action may be directed.

(b) The composition of the board will follow article 18-8(7).

(c) Medical board reports on members involved in alleged misconduct or disciplinary offenses will state fully the nature of the alleged misconduct or disciplinary offenses, including the dates involved. The board will render separate and distinct opinions as to each of the three following questions: (1) At the time of the alleged offense or misconduct, did the accused, as the result of a mental disease or defect, lack substantial capacity to appreciate the criminality of his or her conduct? (2) At the time of the alleged offense or misconduct, did the accused, as the result of a mental disease or defect, lack substantial capacity to conform his or her conduct to the requirements of law? (Note: As used in questions (1) and (2), the term "mental disease or defect" does not include abnormality manifested only by repeated criminal or otherwise antisocial conduct.) (3) Does the accused possess sufficient mental capacity to understand the nature of the proceedings against him or her and the capacity to intelligently conduct or cooperate in his or her defense (competency to stand trial)? In addition, the board will indicate whether, in its opinion, disciplinary action in the form of confinement is (is not) likely to have a deleterious effect on the member's health, and whether disciplinary action probably would (would not) be corrective and (or) lead to a better service adjustment.

(d) In expressing an opinion regarding mental competency and responsibility, the board will consider whether the member, as the result of a mental disease or defect,

lacked substantial capacity either to appreciate the criminality of the member's conduct or to conform his or her conduct to the requirement of law. It is recognized that in certain instances insufficient information will be available for the board to arrive at an opinion in this matter, particularly when a considerable period of time has elapsed since the alleged offenses. In such a case, it is proper for the board merely to state that it is not in possession of necessary information upon which to base a considered opinion. However, the board should express an opinion whenever possible. Such opinion will be based upon the information available at the time.

(e) Opinions as to mental competency to stand trial ordinarily need not be made for individuals who have already been tried and are serving sentence, unless significant information is disclosed which was not available to the court-martial.

(f) Members considered not mentally competent and responsible for the particular act charged or not mentally competent at the time of appearance before a medical board will be recommended for disposition in the same manner as any similar member with no disciplinary action pending. However, medical board reports on such members will be forwarded for Departmental review and appropriate disposition.

(g) Members considered mentally competent and responsible (not lacking substantial capacity) for the particular alleged act and mentally competent to stand trial will be recommended for return to duty for appropriate action. If they manifest personality or behavior disorders rendering them incapable of further useful service, they should be returned to duty for completion of pending disciplinary action and possible administrative separation following guidance in SECNAVINST's 1910.4 or 1920.6 series.

(h) Where a member is involved in disciplinary problems, factors which might operate in mitigation or extenuation will be fully described by the board in its report so that they may be given due consideration by reviewing authorities.

(2) Mental Incapacitation Evaluation.-

(a) Mental incapacitation may result from temporary or permanent physical or mental instability as a result of injury, disease, or other mental condition. Pursuant to chapter 15, JAG Manual, a special board will be immediately convened when it is determined that an individual is mentally incapable of managing his or her personal and financial affairs and a trustee or other representative must be appointed by a court of competent jurisdiction (37 USC 602). The cognizant OMA will ensure that the provisions of this paragraph are applied to those cases where active duty Navy and Marine Corps members are hospitalized in nonnaval medical

facilities. The requirement for this special board is in addition to and separate from the medical board procedures as outlined in the Disability Evaluation Manual and elsewhere in this manual.

(b) The composition of this special board will follow article 18-8(6).

(c) The format of this special board report will be that of a naval letter with the subject "INCAPACITATION EVALUATION; REPORT OF."

(d) After endorsement by the hospital commanding officer, a copy of the special board results will be incorporated into the medical record and inpatient chart, and the original forwarded to Fiduciary Affairs, OJAG, following chapter 15, JAG Manual. Copies will also be provided to the commander of the appropriate regional medical command and to COMNAVMECOM (MEDCOM-25).

(3) Accomplishment of Restoration.—A finding of restoration of competency or capability to manage personal and financial affairs may be accomplished by one or two medical officers or physicians, as appropriate, one of whom must be a psychiatrist. Chapter 15, JAG Manual specifies that JAG liaison is required.

18-15. Patients Who Refuse Medical, Dental, or Surgical Treatment

(1) When a member refuses to submit to recommended therapeutic measures for a remediable defect or condition which has interfered with the member's performance of duty and following prescribed therapy, the member is expected to be fit for full duty, the following procedures will apply:

(a) After being counseled concerning the matter, any member of the naval service who refuses to submit to recommended medical, surgical, dental, or diagnostic measures, other than routine treatment for minor or temporary disabilities, will be transferred to a naval hospital for further evaluation and appearance before a medical board. (See art. 2-18 concerning compulsory medical or surgical treatment.)

(b) After further counseling by the board, the member will be asked to sign a completed NAVMED 6100/4, Medical Board Certificate Relative to Counseling on Refusal of Surgery and/or Treatment. The board will study all pertinent information, inquire into the merits of the individual's refusal to submit to treatment, and report the facts with appropriate recommendations.

(2) Where surgical procedures are in contention, the board's report will contain answers to the following questions:

(a) Is surgical treatment required to relieve the incapacity and restore the individual to a duty status, and may the surgery be expected to do so?

(b) Is the proposed surgery an established procedure that qualified and experienced surgeons ordinarily would recommend and undertake?

(c) Considering the risks ordinarily associated with surgical treatment, the patient's age and general physical condition, and the member's reasons for refusing treatment, is the refusal reasonable or unreasonable? (Fear of surgery or religious scruples may be considered, along with all the other evidence, for whatever weight may appear appropriate.)

(3) If a member needing surgery is mentally competent, surgery will not be performed over the member's protestation.

(4) As a general rule, refusal of minor surgery should be considered unreasonable in the absence of substantial contraindications. Refusal of major surgical operations may be reasonable or unreasonable, according to the circumstances. The age of the patient, previous unsuccessful operations, existing physical or mental contraindications, and any special risks should all be taken into consideration.

(5) In medical, dental, or diagnostic situations, the board should show the need and risk of the recommended procedure.

(6) If a medical board decides that a diagnostic, medical, dental, or surgical procedure is indicated, these findings must be made known to the patient. The board's report will show that the patient was afforded an opportunity to submit a written statement explaining the grounds for refusal, and any statement submitted will be forwarded with the board's report. The patient will be advised that even if the disability originally arose in line of duty, its continuance would be attributable to the member's unreasonable refusal to cooperate in its correction; and that the continuance of the disability might, therefore result in the member's separation without benefits.

(7) The patient will be advised that section 1207 of title 10, U.S. Code, precludes disposition under chapter 61 of title 10, U.S. Code, if such a member's disability is due to intentional misconduct, willful neglect, or if it was incurred during a period of unauthorized absence. The member will be further advised that benefits from the Veterans Administration will be dependent upon a finding that the disability was incurred in line of duty and is not due to the member's willful misconduct. The member will be further advised that the Social Security Act contains special provisions relating to benefits for "disabled" persons and certain provisions relating to persons disabled "in line of duty" during service in the Armed Forces. In many instances persons deemed to have "remediable" disorders have been held not "disabled" within the meaning of that term as used in the statute, and

Federal courts have upheld that interpretation. One who is deemed unreasonably to have refused to undergo available surgical procedures may be deemed both "not disabled" and "not in the line of duty."

(8) The board's report will be forwarded directly to CPEB except in those instances when the convening authority desires that it be referred for Departmental review.

(9) As a matter of policy, a member who refuses medical, dental, or surgical treatment for an EPTE defect not aggravated by a period of active service but which does interfere with the performance of his or her duties should be processed following BUMED INST 1910.2 series and SECNAVINST 1910.4 series rather than under the provisions of this article. In other words, the condition rather than the refusal of treatment should be the deciding factor for determining appropriate disposition.

18-16. Providing Medical Information and Line of Duty/Misconduct Investigation Reports

(1) Navy Medical Department facilities may be asked to provide medical information on individuals being processed by the Director, Naval Council of Personnel Boards (DIRNCPB). Upon receipt of such a request, the action addressee will:

(a) Provide the information requested within 10 working days.

(b) If the requested information requires further evaluation of the member or some other procedure, schedule the member for accomplishment of same on a priority basis.

(c) If unable to comply, provide a message response to DIRNCPB to include the reason for non-compliance and the date the requested information will be provided.

(2) When active duty members are receiving care from the Veterans Administration (VA) for spinal cord injuries, head injuries, or blindness under the provisions of the DOD and VA memorandum of understanding, the VA accepts responsibility for conducting and preparing medical boards on members who have received expedited transfers to VA. However, Navy Medical Department facilities may be required to provide the VA with medical information, line of duty/misconduct (LOD/MIS) investigation reports, and other assistance.

(3) To facilitate disability evaluation processing and effect appropriate disposition of members via medical boards, the following actions are necessary in the timely initiation and reporting of LOD/MIS investigations.

(a) When a member is admitted to a naval hospital for a condition that requires an LOD/MIS investigation, the commanding

officer of the hospital will ascertain from the member's command whether an investigation is being conducted. If an investigation has not been initiated, the hospital CO will promptly report the matter to the area coordinator or designated subordinate commander who will take action to ensure that any required investigation is initiated.

(b) The area coordinator or designated subordinate commander will then take action to comply with the provisions of chapter 8 of the JAGMAN and immediately convene the necessary investigation and furnish required reports.

(4) Timely and complete reports of LOD/MIS findings are essential to proper physical evaluations. Therefore, responsible individuals or commands will, upon receipt of a request from a medical board convening authority, promptly provide such boards with copies of completed LOD/MIS investigations for transmittal in company with medical board reports to the CPEB. Initiation of requests for LOD/MIS investigation reports will be accomplished as soon as it is ascertained that a patient has been admitted or not later than commencement of dictation of a medical board report on either admitted patients or those receiving outpatient care.

(5) When medical board convening authorities are unable to promptly obtain copies of LOD/MIS investigations, they will, nevertheless, transmit to the CPEB reports of associated medical boards without the investigation report. Include reason for absence of the report and copies of correspondence with the activity responsible for the LOD/MIS investigation.

18-17. EPTE Physical Defects

(1) Any member of the naval service may be processed for separation when diagnosed as having a physical defect which existed prior to entry (EPTE) on active service. Waivers for retention will not be granted when the defect would have disqualified the member if discovered at the time of enlistment or induction. The mere presence of a physical defect is not, of itself, reason for separation. The type and degree of the defect and length of service must be considered in processing members with EPTE defects.

(a) Enlisted members found to have a physical defect listed in article 15-30 may be referred to a medical board for disposition following NAVMILPERSCOMINST 1910.2 series or Marine Corps Order P1900.16 series by reason of defective enlistment or enlisted in error when the condition:

(1) Has not been aggravated or worsened by service.

(2) Would have been considered physically disqualifying if discovered at the time of enlistment.

(b) All members of the naval service will be referred to a medical board for recommendation as to disposition when found to have:

(1) A physical defect (defined as a physical disability per SECNAVINST 1850.4 series) which interferes with performance of duty and which (a) is other than that described in subarticle (a) above, and (b) existed prior to entry on active service and has not been aggravated or worsened during that service. BUMEDINST 1910.2 series, MILPERSMAN 3620270, Marine Corps Order P1900.16 series, and SECNAVINST 1920.6 series provide for appropriate disposition in such cases.

(2) Conditions considered physically disabling and which may have been aggravated or worsened by service.

(c) All members of the naval service with a duly diagnosed physical or mental defect not defined as a physical disability (per SECNAVINST 1850.4 series) are subject to administrative separation. A report by a medical board is neither required nor desired unless the member is suffering from other conditions considered physically disabling or upon direction from higher authority. This applies to personality disorders, somnambulism, motion sickness, enuresis, allergy to uniform clothing or bee stings, and excessive height, among others. Medical documentation must support such a diagnosis and the evaluation of the severity of any impairment must substantiate the member's inability to effectively function in a military environment.

(2) For officers, also see article 18-12(5).

18-18. Surgical Procedures on Members in the Disability Evaluation System

(1) Any elective surgical procedure that might affect a member's fitness for duty should be completed prior to initiation of a medical board. When future surgery is anticipated, attending physicians must annotate the medical board report to include this information.

(2) If a nonelective surgical procedure is deemed necessary after a medical board report is submitted to CPEB, a message must be sent to DIRNCPB requesting proceedings be held in abeyance. Make both COMNAVMEDCOM (MEDCOM-33) and the appropriate personnel command information addressees.

(3) After forwarding of medical board reports to CPEB, physicians must assess even more acutely a decision to perform surgery deemed to be in the best interest of the member.

(a) When contemplating an elective procedure, seek the advice of the patient administration officer to assist in assessing whether or not:

(1) The outcome will alter findings of the board.

(2) The outcome will interfere with the member's anticipated disposition, i.e., separation, retirement, or return to duty.

(3) Member will have sufficient time remaining on active duty for appropriate followup care. Do not assume that the Veterans Administration will accept responsibility for this care unless the member has already been accepted as a VA beneficiary.

(b) If a physician believes that an elective procedure should be performed after obtaining the above advice, provide message notification to DIRNCPB and COMNAVMEDCOM (MEDCOM-33) on the planned procedure explaining:

(1) Justification for procedure.

(2) Estimated period of hospitalization and recovery.

(3) Estimated impact of the planned procedure on the fitness of the member for continued service on active duty.

(c) While the ultimate decision on whether to perform an elective or nonelective procedure rests with the member and the attending physician, consideration must also be given to the interests of the Government.

18-19. Limited Duty Medical Boards

(1) General.—When a medical board recommends Limited duty pursuant to article 18-11(2)(a), the limitation imposed by the member's disability will be set forth in the board's report. With the exception noted in (4) below, if a disability is of such a nature that there is a probability that the member will not be fit for full duty after 12 months of limited duty, refer the member's case to the Central Physical Evaluation Board, Arlington, VA.

(2) Limited Duty-6 Months.—The minimum period of limited duty will be 6 months. This does not preclude the medical board from requiring the member to return for reevaluation at specified intervals during the period. Record these followup visits on an SF 600 and filed it in the member's service medical record.

(a) No later than 2 months prior to the end of a 6-months limited duty period, the attending physician must determine if the member will be fit for full duty at the end of the assigned limited duty. If determined to be unfit, the physician must commence a reevaluation board which must be completed and processed by the end of the 6-months limited duty period. Departmental review is required if the finding is for another period of limited duty. Members may be referred to the CPEB at this time if appropriate.

(b) The physician may return a patient to full duty at the conclusion of the 6 months of limited duty, or anytime prior to

the conclusion, by recording the findings, to include residual effects if any, on an SF 600. At this time, the member will be counseled and items 25 and 26 at the bottom of the original Medical Board Report Cover Sheet (NAVMED 6100/1) completed. Results of this action will be provided to the personnel support detachment (PSD) or Commandant of the Marine Corps (MMSR-4), as appropriate, and to the local data services center following local procedures and those in this chapter.

(3) Limited Duty-Up to 12 Months.-It is apparent that some major injuries or illnesses will require more than 6 months limited duty. When this occurs, limited duty may be recommended for up to 12 months but will require Departmental review (also see art. 18-20).

(a) No later than 2 months prior to the end of the limited duty period, the attending physician must determine if the patient will be fit for full duty. If determined to be unfit, the physician must commence a reevaluation board to be completed and processed by the end of the period granted. Such board reports will be referred to the Central Physical Evaluation Board.

(b) On a limited duty board of more than 6 months, the physician may return a patient to full duty at the conclusion, or anytime prior to the conclusion, by recording the findings on the original Medical Board Report Cover Sheet (NAVMED 6100/1). All pertinent findings, to include residual effects if any, will be recorded on an SF 600. Results of this action will be provided to the personnel support detachment (PSD) or CMC (MMSR-4), as appropriate, and to the local data services center following local procedures and those of this chapter.

(4) Limited Duty-Exceeding 12 Months.-As an exception to (3) above, the convening authority may recommend limited duty in excess of 12 months when tuberculosis or a neoplasm (including other diseases of the blood forming organs) is the primary diagnosis and the board membership agrees that (a) a finding of fit for full duty is likely at the conclusion of treatment and (b) the treatment regimen is likely to exceed 12 months. Such a recommendation requires Departmental review. The board report submitted will include the treatment regimen, specifying the number of months normally required, and will adequately justify the exception. The provisions of subarticles 3(a) and (b) above are also applicable to members in a limited duty status in excess of 12 months.

(5) Referral to CPEB.-If during any limited duty period the physician recognizes that the member will not be fit for full duty within the prescribed time frame, a new medi-

cal board will be completed and the case immediately referred to the Central Physical Evaluation Board.

(6) Expiration of Limited Duty.-Initial periods of limited duty will automatically terminate at the end of the prescribed period and the member will be made available for full duty orders following current directives. The expiration date of limited duty will be computed as beginning on the date the physician conducts the examination upon which the board is dictated. The memorandum endorsement on the NAVMED 6100/1 will be used when limited duty automatically expires. This will allow physicians to return members to full duty without formal board action. Head of department or appropriate directorate signature must be obtained. Space is provided for the member's signature to indicate understanding of the terms of return to full duty without formal medical board action.

(7) Departmental Review.-When the convening authority of a limited duty medical board is a commanding officer of a naval hospital, an initial period of limited duty of 6 months may be approved for enlisted personnel without Departmental review. Departmental review is required when (a) the recommended period of limited duty exceeds 6 months, (b) a second period of limited duty is recommended, (c) the member submits a statement in rebuttal to the board's findings or recommendation, (d) the medical board involves other than an enlisted member, or (e) the medical board is ordered by other than the convening authority.

(8) Return to Full Duty.-Return to full duty for all officers requires a complete medical board. Return to full duty from a limited duty status is not adverse action. Nevertheless, an enlisted member may question the appropriateness of this action. If an enlisted member does not agree with a physician's decision of return to full duty, resolution should first be attempted between that member, the attending physician, and the physician's directorate/department head the same as any other difference of opinion regarding medical care. Should this review determination uphold the return to full duty status, the enlisted member will be made available for assignment and must be informed of the right to submit an appeal through the chain of command. If the enlisted member elects to contest the finding of fit for full duty, the member may submit a request to the commanding officer of the naval medical treatment facility returning that member to full duty, via the member's commanding officer. The appeal package should include statements relevant to the condition upon which the appeal is based; copies of all pertinent medical records, including the latest and all previous medical boards relating to

the current condition; and any nonmedical documentation, e.g., a statement by the member's commanding officer concerning the member's ability to perform full duty. Availability for assignment to full duty will not be held in abeyance during these procedures. Officers will be returned to full duty only after evaluation by the formalized medical board process (see article 18-12).

18-20. Permanent Limited Duty Medical Boards

(1) Medical boards recommending permanent limited duty will be referred to the PEB.

(2) A member who is deemed fit for full duty at any time subsequent to the assignment of a permanent limited duty designator by COMNAVMILPERSCOM or MARCORPS following MILPERSMAN 1830120 or pertinent MARCORPS directives, will be reevaluated by a medical board and the report thereof submitted for Departmental review.

18-21. Special Medical Boards

(1) Current regulations permit the acceptance into the Navy or Marine Corps of a physically unqualified individual provided (a) it is determined at the Departmental level that the individual has, in the pursuit of a civilian occupation, profession, or avocation, demonstrated that satisfactory active service can be performed; and (b) a waiver of the physical standard is recommended by COMNAVMEDCOM and granted by COMNAVMILPERSCOM or MARCORPS, as appropriate. It is possible that the member may subsequently demonstrate the inability to perform satisfactory service by reason of the previously waived defect. In such situations, the procedures set forth below will be observed.

(a) Appropriate evaluation is required with subsequent appearance before a medical board. The board's report will include statements from the member's division officer, department head, or executive officer describing any functional impairment that might be attributed to the previously waived defect.

(b) The medical board will make appropriate recommendations regarding the member's fitness to perform satisfactory active service.

(c) When endorsing the board's report, the convening authority will indicate concurrence or nonconcurrence with the board's findings and recommendations, and make such other comments as may be considered pertinent to the member's defect or ability to perform satisfactory service.

(d) The board's reports will be forwarded to COMNAVMILPERSCOM or MARCORPS, as appropriate, via COMNAVMEDCOM (MEDCOM-25).

18-22. Board Procedures

(1) Medical boards will consider and report on members referred by competent authority. Boards will require and examine such records as are necessary to formulate a considered conclusion regarding the member's present state of health and the recommendations required. The board's report and recommendations will be read to and discussed with the member by the cognizant medical officer provided that, in the opinion of competent medical authority, such discussion will not adversely affect the member's health.

(2) Unless it is considered that the information contained in the board's report might have an adverse effect on the member's physical or mental health:

(a) The member will be allowed to read the board's report or be furnished a copy thereof.

(b) Significant findings, opinions, and recommended disposition will be brought to the member's attention.

(c) The member will be afforded an opportunity to submit a statement in rebuttal to any portion of the board's report. If a member submits a statement in rebuttal, the board will review same and make any change considered appropriate or prepare a statement in surrebuttal.

(3) The form NAVMED 6100/2 statement concerning contents, opinions, and recommendations of the medical board will be completed, referred to the member for signature, and witnessed. Upon signing the form, members will enter their grade or rate and service status, either Regular or Reserve, and social security number. This form and the statement in rebuttal (and surrebuttal), if any, will accompany the board's report but will not be incorporated into it.

(a) After a member has accepted recommended findings, elective medical or surgical procedures (see article 18-18 for rules on surgical procedures) normally should not be performed. If a procedure is deemed necessary for such a member, make prompt notification so that disability proceeding can be held in abeyance.

(b) If a member has not accepted recommended findings and an elective procedure is medically determined to be in the member's best interest, the procedure may be performed if determined that the procedure will not adversely affect the member.

(4) The report of the medical board may be amended with new or additional findings

or recommendations by submission of an addendum to the original board report.

(5) The convening authority will immediately advise addressees of the medical board of any change of condition which may materially affect the disposition of the patient. This includes improvement or worsening of a previously reported defect or condition.

18-23. Board Preparation

(1) Medical board reports will be submitted to the convening authority on NAVMED 6100/1 (Medical Board Report Cover Sheet). An SF 502 (Narrative Summary) may be used for the body of the board's report provided the SF 502 includes all pertinent data concerning the member. Otherwise, the body of the report will be prepared on plain white bond paper.

(a) The cover sheet will be completed following the guidelines in article 18-26.

(b) The body of the report will present, in narrative form, all pertinent data concerning each complaint, symptom, disease, injury, or disability presented by the member which causes or is alleged to cause impairment of health. The facts should be presented briefly and concisely. Emphasis must be placed on the detailed recording of each physical disability in such a manner that subsequent evaluation by adjudicative bodies can be made on the basis of the records.

(c) The narrative section of board reports should be no more and certainly no less than a well written narrative summary and should answer the following questions:

- (1) Why was patient hospitalized?
- (2) What physical findings (negative and positive) were found?
- (3) What were the results of pertinent laboratory and x-ray tests?
- (4) What medical or surgical treatment was rendered?
- (5) What was the current physical condition of the patient at the time the medical board report was written?
- (6) What is the board's prognosis and recommendations concerning the disposition to be effected?
- (7) What instructions were given to the patient, such as medication to be taken, physical restriction, etc.?
- (8) Have all conditions and abnormalities been recorded?

(2) Since the medical board is considered the heart of the Navy's disability evaluation system, incomplete, inaccurate, misleading, or delayed reports may result in an injustice to the member or the Government.

(a) The mere presence of a physical disability does not necessarily render the member unfit for duty. The history of the

member's illness; objective findings on examinations; results of x-ray and laboratory tests; reports of consultations; and subjective conclusions with the reasons therefor are pertinent evidence to support findings and recommendations. The board's report will clearly reflect the member's functional impairment, if any.

(b) Apparent contradictions in the records, such as disagreement with a report or consultation, should be thoroughly explained. The condition of a patient following therapy, the response thereto, the degree of severity of the disease or injury, and when appropriate, their effect on the member's functional ability must be described in detail.

(3) If a previous medical board report has been prepared, it is not necessary to repeat the detailed information contained therein pertaining to past history. Attention may be invited to the previous report and the description of the present illness restricted to the interval history and currently pertinent data.

(4) Any facts which are not a matter of record or of personal knowledge to a member of the board, but which are based on the member's own statement, should be recorded as "according to the member's own statement." Such data are obtained primarily for the benefit of the patient in diagnosis and treatment, and may be used for the purpose of further interrogation of the patient if pertinent. Any additional history so obtained, from the patient or from other sources contacted as a result of "lead information", may be incorporated as part of the history.

(5) In the following instances, the board's report will contain a statement concerning the member's capability to manage personal affairs.

- (a) All psychoses.
- (b) Organic brain disorders when the board's report indicates impairment of judgment.
- (c) Psychoneuroses, severe, when possible impairment of judgment is indicated.
- (d) Any situation in which a member has previously been declared incapable of managing personal affairs.
- (e) All psychiatric illnesses of sufficient severity to require further hospitalization.

(6) In those instances enumerated in sub-article (5) above, the board membership will follow article 18-8(6) where either mental incompetency or mental incapacity is found.

(7) Except where considered necessary, the information reported on the cover sheet need not be repeated in the body of the board's report.

(8) Where severe disfigurement is involved or for chronic skin conditions, the submission of photographs is encouraged.

(9) Statistical coding of medical board reports will follow the guidelines in articles 18-25(9) and 18-28.

18-24. Processing Time

(1) For each individual medical board, the processing time between dictation and signature by convening authority will not exceed 10 working days.

18-25. Report Routing and Disposition

(1) In preparing medical boards for mailing for Departmental review of referral to the CPEB, the package will be assembled in the following manner:

(a) Original or a copy of current medical board as required.

(b) Single copy of previous boards relating to current condition(s).

(c) Two copies of current board.

(d) Single copy of Health Record, if indicated.

(e) Single copy of clinical records, if indicated.

(2) Original and two copies of the medical board report on Coast Guard members will be referred to the Commandant of the U.S. Coast Guard via the commanding officer of the unit to which attached or via the district Coast Guard officer of the district in which the medical facility is located. Copy to Health Record. Copy to clinical record. (See art. 18-33 on Coast Guard members.)

(3) Original and two copies of the medical board report on Army and Air Force members will be referred to the local liaison officer. (See article 18-31.)

(4) Original and two copies of the medical board report will be inserted in the Health Record of Navy and Marine Corps members separated under BUMEDINST 1910.2 series and the Health Record closed and handled as in article 16-9(3). Copy to service record. This is a responsibility of the separation activity. The separation activity is also responsible for endorsing the original medical board report to show the date and authority for separation.

(5) Original and two copies of the medical board report to Central PEB on those Navy and

Marine Corps members referred to a PEB by the convening authority. Copy to service record. Copy to clinical record. Refer to article 18-13 regarding appropriate disposition of medical board reports when disciplinary action, involuntary separation, or investigative proceedings are pending.

(6) Three copies of the medical board report (one signed by board members and convening authority) to COMNAVMEDCOM (MED COM-25) on all Navy and Marine Corps officers returned to limited duty or full duty. Original to Health Record. Copy to clinical record.

(7) Original to Health Record. Copy of Medical Board Report Cover Sheet (NAVMED 6100/1) to service record, and copy of complete medical board to clinical record on all Navy and Marine Corps enlisted members returned to 6 months limited or full duty.

(a) Three copies of the medical board report (one copy signed by board members and convening authority) to COMNAVMEDCOM (MED COM-25) on all reports involving limited duty in excess of 6 months. Original to Health Record (HR). Copy to clinical record.

(b) In all situations involving reevaluation, following an initial period of limited duty, when the convening authority approves the board's recommendation for an additional period of limited duty, three copies of the medical board report (one copy signed by board members and convening authority) will be forwarded to COMNAVMEDCOM (MED COM-25).

(8) Three copies of the medical board report (one copy signed by board members and convening authority) will be forwarded to COMNAVMEDCOM (MEDCOM-25) in all other Navy and Marine Corps reports where Departmental action is indicated. Original to HR. Copy to clinical record, if available.

(9) The first carbon copy of each medical board report will be submitted for automatic data processing as set forth below:

(a) Subsequent to action by the convening authority and prior to submission to the assigned Naval Medical Regional Data Center (NMRDC) for automatic data processing, the activities listed below will accomplish statistical coding of the first carbon copy in the spaces provided following NAVMEDCOM INST 6100.1 series. Activity assignment to NMRDC's are:

Activity

NMRDC

Naval Hospitals and U.S. Naval Hospitals

The Naval Medical Regional Data Center assigned by section XV of BUMEDINST 6300.3 series.

Marine Corps Recruit Depot, Parris Island, SC.....
Marine Corps Base, Camp Lejeune, NC
Marine Corps Base, Camp Pendleton, CA
Naval Training Center, Great Lakes, IL
Marine Corps Recruit Depot and Training Center, San Diego, CA
Naval Training Center, Orlando, FL

NAVHOSP Beaufort, SC
NAVHOSP Camp Lejeune, NC
NAVHOSP Camp Pendleton, CA
NAVHOSP Great Lakes, IL
NAVHOSP San Diego, CA
NAVHOSP Orlando, FL

(b) All other activities authorized to conduct medical boards will forward the first carbon of the Medical Board Report Cover Sheet (statistical coding not required) to the Commanding Officer, Naval Medical Data Services Center, Bethesda, MD 20814.

(c) Submission schedules for the statistically coded Medical Board Report Cover Sheets to the NMDRC for activities assigned in (a) above are in NAVMEDCOMINST 6100.1 series.

(d) Activities assigned to NAVMEDATA SERVCEN Bethesda, Maryland will accumulate and forward the first carbon copies of the Medical Board Report Cover Sheets in batch lots monthly in time to reach the NAVMEDATA SERVCEN by the 15th of the following month. Forward via air mail where appropriate.

(10) When a member is separated under BUMEDINST 1910.2 series by reason of an EPTE condition that is not service aggravated and regardless of length of service, the separation activity will forward copies of the following documents to Commander, U.S. Military Entrance Processing Command, 2500 Green Bay Road, North Chicago, IL 60064.

(a) Original enlistment SF 88 and 93.

(b) Separation SF 88 and 93, if completed.

(c) Medical Board Report Cover Sheet, NAVMED 6100/1.

(d) Medical board narrative.

(11) One copy of the medical board report and, if required, the original flight physical examination report (SF 88), to NAMI (NAMI-14) on all Navy and Marine Corps aviation officers and aviation enlisted personnel, regardless of disposition or other submissions.

(12) One copy of the reports prepared by medical boards convened pursuant to 18-11(2)(f) and section 1504 of JAG Manual will be forwarded to cognizant authorities as required by section 1505, JAG Manual.

(13) On all submarine officers and submarine enlisted personnel regardless of disposition or other submissions, provide COMNAVMEDCOM (MEDCOM-21) with one copy of the medical board report, the original submarine physical examination report (SF 88), the original report of medical history (SF 93), and any required consultations.

18-26. Medical Board Report Cover Sheet (NAVMED 6100/1)

Item 1, FROM/TO/VIA.-

FROM.-Enter the name and address of the medical facility where the medical board was held.

TO.-Enter COMNAVMILPERSCOM, Commandant of Marine Corps, or the convening authority, as applicable. See article 18-25 regarding Army, Air Force, and Coast Guard personnel.

VIA.-Enter the name and location of the convening authority, other administrative commands in the chain of command and the Commander, Naval Medical Command, Washington, DC 20372-5120, if applicable.

Item 2, NAME.-Enter last name, first name, and middle initial of the member appearing before the board.

Item 3, DUTY STATION.-Enter the official name and address of the duty station (shore base or ship) to which the member was permanently attached at the time the condition arose which precipitated the board. For second and subsequent boards, note present duty station but also indicate, under remarks, the member's duty station when the initial board was held.

Item 4, SOCIAL SECURITY NUMBER.-Enter the member's nine-digit social security number.

Item 5, SEX/RACE.-Enter "M" for male or "F" for female, and enter one of the following as applicable for race: Caucasian, Negroid, Mongolian, American Indian, or Malayan.

Item 6, DATE OF BIRTH.-Enter numeric date, month (numeric symbols not authorized), and calendar year of birth of member.

Item 7, LENGTH OF SERVICE.-Enter length of service in years and months. All active duty service in all U.S. uniformed services will be counted. Example: For less than 12 months active service, use 00 (NO) years and numbers of months completed. If less than 1 month active service, use 00 (NO) years and 00 (NO) months. For 12 months active service use 01 (one) year and 00 (NO) months.

Item 8, GRADE/RATE, BRANCH, AND DESIGNATOR/MOS.-

(1) Grade/Rate.-Enter the grade or rate abbreviation of the member. For Navy and Coast Guard enlisted personnel include the rate i.e., a Hospital Corpsman, Second Class, enter HM2.

(2) Branch.-Enter branch of service; i.e., USN, USMC, USA, USAF, USCG, and Reserve components.

(3) Designator/MOS.-This item must be completed for naval officers and all Marine Corps members as set forth below.

(a) Navy Officer/Warrant Officer.-Enter the four digit designator from the Register of Commissioned and Warrant Officers of the Navy and Marine Corps and Reserve Officers on Active Duty, NAVPERS 15018.

(b) Marine Corps Officer and Enlisted.-Enter the four digit Military Occupational Specialty (MOS) number from the Military Occupational Specialty Manual (Marine Corps Order P-1200.7).

(c) Midshipmen, Cadets, and Members of the Coast Guard, Army, and Air Force.-Leave blank.

Item 9, CAUSE OF INJURY.-If the condition entered as item 19A (Primary Diagnosis) is

not the result of an accident, violence, or poisoning, enter "Not applicable"; otherwise enter one of the following:

(1) Battle casualty.-- (Self-explanatory.)

(2) Motor vehicle.-- (Includes automobile and motorcycle accidents.)

(3) Falls.-- (Includes falls either on the same or different levels on land or on ship.)

(4) Athletics and sports.-- (Includes situations involving accidents in organized recreation whether for training purposes or not.)

(5) Assault by another.-- (Includes situations involving injuries received as a result of fighting or attack by another person.)

(6) Self-inflicted.-- (Includes situations involving both accidental and intentionally self-inflicted wounds.)

(7) Other external cause.-- (Includes situations involving accidents, violence, or poisoning with causes not classifiable above.)

Item 10, MILITARY THEATER OF OPERATION.-- Enter the military theater of operation to identify the geographic origin of the disease or injury and indicate whether or not the condition necessitating a medical board was a result of hostile or nonhostile action. Use only when directed by COMNAVMEDCOM.

Item 11, MEMBER'S STATUS.-- Record the appropriate number in the box. The term recruit applies to Navy or Marine Corps personnel undergoing basic training. Midshipmen and aviation cadets will be indicated as "Active Duty Navy."

Item 12, DATE AND PLACE OF ENTRANCE PHYSICAL.-- Enter the name and location of facility that conducted the entrance physical examination if the member has less than 1 year of active service; otherwise leave blank.

Item 13, EAOS/AOS.-- Enter the date of expiration of active obligated service. For officers enter "INDEFINITE" if applicable.

Item 14, ADMITTED TO SICKLIST.-- Note: Admitted to Sicklist indicates currently on the sicklist or having recently been on the sicklist and discharged awaiting appearance before the medical board being reported. If admitted after the date of the medical board, the "NO" block will be checked.

Item 14a, ADMITTED TO SICKLIST.-- Place an "X" in the appropriate box to indicate whether or not the member was admitted to the sicklist for the condition for which the medical board was held.

Item 14b, DATE OF DISPOSITION.-- Enter numeric date (YR/MONTH/DATE). If not admitted enter "NA".

Item 15, DATE OF BOARD.-- Enter the date (YR/MONTH/DATE) that the board was held. Do not record the date the report was typed, signed, or forwarded.

Item 16, EPTE (ORIGIN).-- Appropriate numbers to be used in blocks 19A through 19F. In determining the proper entry, refer to article 18-17.

Item 17, LOD INVESTIGATION.-- Place an "X" in the appropriate box if the LOD investigation has been completed by the cognizant command. If the investigation has not been completed, enter the name of the command in the remarks section with amplifying information as to the projected completion date.

Item 18, DISCIPLINARY ACTION PENDING.-- Place an "X" in the appropriate box. Enter the name of the command processing this action in the remarks section. Where "YES" is indicated, the board must be forwarded for Departmental review.

Items 19A through 19F, DIAGNOSIS/DIAGNOSES.-- Instructions for recording:

(1) General.-- Information on established diagnoses related to the medical board are needed, not only for legal reasons but also for planning and evaluation purposes at COMNAVMEDCOM and other Departmental levels. The diagnostic nomenclature to be used in recording these diagnoses will be based on and consistent with current medical terminology. International Classification of Diseases, 9th Rev., Clinical Modification (ICD-9-CM) and Diagnostic and Statistical Manual of Mental Disorders (DSM), current editions, will be used for establishing diagnoses. When recording diagnoses, care should be taken to make them as complete and definite as possible. Avoid vague and general expressions.

(2) Order of Diagnoses.-- Space has been reserved for the recording of six diagnoses. The first diagnosis listed--PRIMARY DIAGNOSIS--should be the major diagnosis or condition for which the medical board was convened. Where there is more than one diagnosis or condition to be recorded, the following rules apply.

(a) If the diagnoses are unrelated, the primary should be the most significant.

(b) If there is a combination of related causes, the primary diagnosis should be the one which was determined to be the precipitating factor for the other diagnosis or diagnoses. For example, in a diagnosis of "schizophrenic reaction acute, undifferentiated type due to drug ingestion, LSD and Mescaline," the diagnosis "drug ingestion" will be considered the primary diagnosis.

(c) Record the second through sixth diagnoses in order of importance.

(3) EPTE Origin.-- From item 16, enter the appropriate number in the box provided for the origin of each diagnosis entered. Refer to article 18-17 for guidance.

Item 20, INDICATED DISPOSITION.-- Enter the appropriate number in the box provided.

(1) When the indicated disposition of the board is discharge from the service by reason of a physical disability, which the

board considered as not incurred in nor aggravated by service, the member will be fully advised that under section 1214 of title 10, United States Code, such members are entitled, as a matter of right, to a full and fair hearing before a PEB, if the member demands such a hearing. Should the member, after being advised of the rights to a full and fair hearing, not desire such a hearing prior to the member's discharge, certification by the member on NAVMED 6100/3 (Medical Board Certificate Relative to a PEB Hearing) is required.

(2) When the indicated disposition is discharge by reason of convenience of the Government due to personality disorders or mental retardation, the member will sign a NAVMED 6100/2 (Medical Board Statement of Patient) which indicates that the member has been informed of the board's findings and does not desire to submit a statement in rebuttal. The member's signed NAVMED 6100/2 will be forwarded instead of a NAVMED 6100/3 which has no application in the absence of a physical disability.

Item 21, REMARKS.—Indicate the YR/MONTH/DATE that the period of limited duty automatically expires. Compute expiration date from the date the physician conducts the examination upon which the board is dictated. Item may also be used to enter amplifying information from preceding items. When the indicated disposition is limited duty, the board will set forth the major physical limitation imposed by the member's condition and the length of time the member should be retained in a limited duty status.

Item 22, BOARD MEMBERS AND SIGNATURES.—Type the name, grade, corps, and branch of service of each member. Signatures of each member will appear in the space provided. Indicate a psychiatrist by placing a (P) after the typed name. Indicate a clinical psychologist by placing a (CP) after the typed name. Facsimile signature stamps will not be used. Copies of medical board reports submitted for Departmental review or action must include one signed copy.

Item 23, ENCLOSURES.—Place an "X" in the appropriate box or boxes as indicated.

Item 24, CONVENING AUTHORITY ACTION.—Type the name, grade, corps, and branch of service of the convening authority. The convening authority must indicate approval or disapproval and whether any administrative involuntary separation action is pending.

(1) The convening authority will adhere to the following:

(a) Where the convening authority of the medical board concurs, such official will endorse and forward an original and two copies of the medical board report and other required documents to the Central PEB located in the Naval Council of Personnel Boards, 801 N. Randolph Street, Arlington, VA 22203. In

this connection, a copy of the member's current Health Record and the following clinical record documents will accompany the medical board report — a copy (photostatic, quick-copy, typed, etc.) of the history, physical examination, doctor's progress notes; all laboratory, x-ray, and operative reports; and all consultations. In addition, color photographs (2 x 2 inch (5.08 x 5.08 cm) color slides are acceptable) should be provided in instances of scarring with disfigurement, pigmentation changes, or when unusual deformities such as ankylosis of individual fingers are present. Additionally, a copy of the investigative or injury report will accompany the medical board report, when appropriate. Whenever a copy of the investigative or injury report is required but not available, attach to the medical board report, with a statement explaining the circumstances of injury, a copy of all communications initiated by the hospital to obtain a copy of the investigative or injury report and copies of all replies. Orders will not be issued for personal appearance before a PEB until, and unless the Naval Council of Personnel Boards (Central PEB) advises the appropriate authority that the member has requested personal appearance before the board. Also, orders for personal appearance will not be issued for mentally incompetent members. The Disability Evaluation System refers all reports involving mentally incompetent members to a PEB empowered to conduct formal hearing for action by qualified counsel. Whether such a hearing is deemed necessary is a decision of the qualified counsel after consultation with the member's legal representative.

(b) Where the convening authority of the medical board does not concur, the convening authority will advise the member concerned of the nonconcurrence and afford the member an opportunity to submit a statement in rebuttal. The convening authority will then forward the medical board report, the member's signed statement, and a full statement setting forth the reasons for nonconcurrence to the COMNAVMILPERSCOM or CMC, as appropriate, via the COMNAVMEDCOM, Washington, DC, for determination as to disposition to be effected.

(c) Orders for a personal appearance before a PEB empowered to conduct a formal hearing will be issued by the authority which referred the medical board report to the disability evaluation system upon notification from the Director, Naval Council of Personnel Boards (Central PEB), that such appearance has been requested by the party or that a formal hearing is in the best interest of the party and the Government. Personnel who are in a patient status will be transferred from hospital to hospital for personal appearance before a PEB per U.S. Navy

Travel instructions. Transportation through facilities of the Medical Air Evacuation System will be used to the fullest extent possible.

(d) If further hospitalization is indicated, the member will be retained on the sicklist until recommended findings have been made by the Central PEB. If further hospitalization is not indicated, the member may be discharged from the sicklist and transferred to a nearby appropriate administrative command to await counseling. The member will not be sent home awaiting orders, granted other than emergency leave, or transferred to another activity until the recommended findings of the Central PEB have been received and accepted by the member. In those situations where the member has been discharged from the sicklist and does not accept the recommended prima facie findings of the Central PEB, the member will be transferred to the hospital nearest the Regional PEB, as designated by the Central PEB, for the conduct of a hearing. The transfer will be accomplished when requested by the Regional PEB using accounting data provided by the Central PEB.

(e) With the consent of the member, the convening authority of a medical board may, for good and sufficient reason, withdraw any medical board report the convening authority has referred to the Central PEB so long as the report is still before the Central PEB and recommended findings have not been made by the Central PEB. The convening authority may, with the consent of the member concerned, request the COMNAVMIL PERSCOM or CMC, as appropriate, or COMNAVMEDCOM to withdraw the entire report under the provisions of part XI of the Disability Evaluation Manual.

(2) Where the indicated disposition of the medical board is other than appearance before a PEB:

(a) The convening authority of the medical board will include a statement in the forwarding endorsement indicating whether final action has been taken on the medical board report by authorizing local action, and whether or not an availability report for reassignment has been submitted as required by MILPERSMAN 1810520.13a or the ENLTRANSMAN. If the report is submitted to the Navy Department for action, the convening authority will state whether the member has been retained on the sicklist; or, if discharged from the sicklist, the station to which transferred to await Departmental action on the report.

(b) In all medical board reports where the indicated disposition of the board is to place an officer of the Navy or Marine Corps on limited duty or full duty and the convening authority concurs, the report with the officer's signed statement will be forwarded to COMNAVMEDCOM (MEDCOM-25) for Departmental review.

(c) In those medical boards where the indicated disposition of the board is to place an enlisted Navy or Marine Corps member on 6-months limited duty, the convening authority may approve the board's report without Departmental approval, provided the following criteria are met: (1) it is the member's first period of limited duty for the current condition, (2) it is reasonably expected that the member will be able to return to full unrestricted duty on a worldwide basis in the member's rate and MOS following the initial period of limited duty, and (3) the member did not submit a statement in rebuttal to the board's findings or recommendation. The convening authority will refer all board reports to COMNAVMEDCOM (MEDCOM-25) where the period of limited duty is for more than 6 months. Subsequent periods of limited duty must also be referred to COMNAVMEDCOM (MEDCOM-25) for Departmental review. In all other situations not meeting the above criteria or where the convening authority does not desire to approve the board's recommendation for limited duty, the board's report will be referred to COMNAVMEDCOM (MEDCOM-25) for Departmental review.

(d) In those medical board reports where the indicated disposition of the board is to place an enlisted Navy or Marine Corps member on full duty, the convening authority may approve the board's report, without Departmental approval, provided the following criteria are met: the board's report does not recommend any geographical or physical limitations that would preclude worldwide sea or shore assignment in the member's rate and MOS, assignment to a combat zone, or the requirement for followup treatments or evaluations that could not be accomplished by other than a naval hospital. In medical board reports not meeting the above criteria or when the convening authority does not desire to approve the board's report for return to full duty, the board's report will be referred to COMNAVMEDCOM (MEDCOM-25) for Departmental review.

(e) In those medical board reports submitted for Departmental action wherein a previous medical board report is referred to in the current board's report, provide a copy of the previous medical board report so reviewing authorities can have access to all available data. Similarly, copies of pertinent consultations and narrative summaries of recent hospitalization at other activities should be appended to the medical board report.

(f) In those medical board reports where the member has refused medical, dental, or surgical treatment for a condition or defect which has interfered with the performance of duty (see art. 18-15), the board's report will be forwarded directly to the Central PEB except where the convening authority desires that the medical board report be referred for Departmental review.

(g) In all medical board reports, except those convened at activities authorized to take action following the special instructions published in BUMEDINST 1910.2 series, where the indicated disposition is release from active duty, discharge, or where the indicated disposition is that a revocable commission be revoked by reason of unfitness or convenience of the Government, the board's report together with the applicable NAVMED 6100/3 certificate or the member's NAVMED 6100/2 statement will be forwarded to COMNAVMEDCOM (MEDCOM-25) for Departmental review. Where applicable and when appropriate, members will be transferred to the nearest separation activity in the contiguous United States to await Departmental review of their medical board report.

(h) The convening authority of the medical board will include in the endorsement, concurrence or nonconcurrence in the board's report, and such other comment as is considered warranted about any part of the report; particularly when the convening authority does not concur in the opinions or recommendations of the board. The convening authority of the medical board appropriately may discuss with the board and advise or recommend changes in opinions or recommendations if such are contrary to law or to sound medical judgment, but it is not appropriate to direct that the board arrive at specific findings or recommendations.

(i) When the indicated disposition is to place a member on limited duty or full duty and the convening authority does not concur, the convening authority will advise the member concerned of the nonconcurrence and reasons therefor and afford the member an opportunity to submit a statement in rebuttal. The convening authority will then forward the board's report, the member's signed statement, and a full statement setting forth the convening authority's reasons for nonconcurrence, to COMNAVMEDCOM (MEDCOM-25) for Departmental review.

(j) All medical board reports except those referred to a PEB, will be completed and forwarded for machine processing as set forth in article 18-25(9).

Item 25. MEMORANDUM ENDORSEMENT UPON REEVALUATION.—When a member is found fit for full duty after the initial period of limited duty, the attending physician will assure the completion of the remainder of the form. Examination findings, to include residual effects, will be recorded on an SF 600. The summary findings, fitness for duty, and date returned to full duty will be recorded in this item.

(1) Type the examining physician's name, grade, corps, and service. The physician signs and provides date signed.

(2) Type the member's name, grade, rate, and service. Once the member signs and provides the date signed, the member has

acknowledged that he or she has been counseled and understands the finding of fit for full duty.

(3) Type the name of the directorate or head of department, grade, corps, and service. Obtain his or her signature and the date signed.

Item 26. MEMBER TRANSFERRED TO.—Indicate activity to which the member has been transferred to await final action.

18-27. Return to Duty—Aviation, Submarine, and Other Special Duty Personnel

(1) General.—A finding of "fit for duty" by a medical board does not in itself constitute a finding of fitness for special duty assignment. Personnel requiring a determination of fitness for specialized duty will be evaluated upon completion of the medical board proceedings.

(2) Aviation Personnel.—

(a) Officer aviation personnel will be processed following article 18-12(4).

(b) Aeronautically designated enlisted personnel will be referred to the nearest naval activity with an assigned flight surgeon for determination of their fitness for duty involving flying. This administrative action should be accomplished by the PSD of the member and is separate from the medical board proceedings.

(3) Submarine Personnel.—Prior to being made available for detailing, submarine personnel found fit for return to full duty following a period of limited duty will have an undersea medical officer perform a health record review and physical examination for determination of fitness for submarine duty. As a minimum, this procedure will be documented on the Chronological Record of Medical Care (SF 600) and signed by the undersea medical officer.

(4) Occupational Exposure to Ionizing Radiation Personnel.—A medical officer will review the physical qualifications of members from positions or billets requiring occupational exposure to ionizing radiation before making the member available for detailing. This ensures that such members continue to meet requirements of the Radiation Health Protection Manual (NAVMED P-5055). An entry reflecting this examination will be made in such members' Health Record on an SF 600, Chronological Record of Medical Care. If the review indicates that such member may not be qualified, a new occupational exposure to ionizing radiation physical examination will be accomplished following NAVMED P-5055 before return of the member to duty.

(5) Other Special Duty Personnel.—When found fit for return to duty after a period of limited duty, other personnel requiring special duty qualifications will be evaluated following appropriate governing direc-

tives prior to being made available for detailing.

18-28. Automatic Data Processing Procedures

(1) Statistical coding of the first and second carbon copies of the Medical Board Report Cover Sheet will be the responsibility of the activity where the medical board was held, with exception of those activities forwarding the carbon copy to the Naval Medical Data Services Center, Bethesda, MD. Coding in such instances will be the responsibility of the NAVMEDATASERVEN per current COMNAVMEDCOM directives.

(2) Statistical coding of the second carbon copy of the Medical Board Report Cover Sheet will be the responsibility of the activity where the reevaluation is held. File this copy in the Health Record until the reevaluation is completed and the final disposition has been recorded. Coding will follow current COMNAVMEDCOM directives.

(3) Upon receipt of the statistically coded copy, machine processing procedures will be initiated following guidelines in NAVMEDCOMINST 6100.1 series.

(4) Questions regarding statistical coding of the Medical Board Report Cover Sheet will be directed to the Naval Medical Data Services Center (NAVMEDATASERVEN).

18-29. Health Record Entry

(1) An entry will be made in the member's Health Record on the SF-600, Chronological Record of Medical Care and NAVMED 6150/4, Abstract of Service and Medical History noting the name of the examining facility, date of evaluation, diagnosis, and recommended disposition. Final disposition will be noted when approved.

(2) The original of each report by a medical board, special medical board, or to determine mental competency or incapacitation will be filed in the member's Health Record.

18-30. Availability Reports and Reassignment of Personnel

(1) The officer availability reports required by MILPERSMAN 1810520.13a must be submitted promptly if the officer is in an outpatient status.

(2) The Enlisted Transfer Manual (ENLTRANS MAN) requires the submission of an availability report on all Navy enlisted members who have appeared before a medical board that recommends a period of limited duty or return

to full duty after completion of a period of limited duty. Once the medical board is approved, the responsibility for ensuring timely submission of availability reports rests with the personnel support detachment (PERSUPPDET) to which the member is transferred for availability processing and further assignment. It is therefore an absolute necessity that the convening authority of medical boards provide proper notification, via submission of a copy of the Medical Board Report Cover Sheet (NAVMED 6100/1), to the PERSUPPDET so that availability reports are in fact submitted as required by ENLTRANS MAN, chapter 20.

(3) Marine Corps members who appear before a medical board that recommends a period of limited duty or return to full duty after completion of a period of limited duty are to be referred to the Marine Corps liaison official (if available), returned to their parent command, or transferred to the nearest Marine Corps activity, with the original medical board report, to ensure appropriate assignment in a timely manner.

18-31. Triservice Medical Boards

(1) Members of the Air Force or Army will not be transferred from naval medical treatment facilities for the sole purpose of convening medical boards. Treatment facilities will convene a medical board per BUMEDINST 6100.6 series, when requested by appropriate authorities of the member's service, upon any such member receiving care in a naval medical treatment facility. In addition to reasons that may be provided by the Army or Air Force in individual instances, article 18-11 addresses circumstances under which these members should be referred to a medical board.

18-32. Disposition Table

(1) The table on the following page provides assistance and guidance to field activities regarding the disposition of medical board reports on active duty Navy and Marine Corps members following the convening authority's action. See articles 18-25 and 18-31 for disposition of reports for other Armed Forces personnel.

(2) For guidance in handling the exceptions, refer to applicable articles in this chapter and the special provisions of BUMED INST 1910.2 series. In all medical board reports where there is doubt as to the disposition to be effected, referral to COMNAVMEDCOM (MEDCOM-25) is appropriate.

Medical Board Recommendations	Convening Authority Concurs	Member Submits Rebuttal	Disposition of Medical Board Report
Refer to PEB (OFF/ENL)...	Yes	No	Code 1
Do	Yes	Yes	Code 2
Do	No	Yes or No	Code 2
Limited Duty (Enl)	Yes	No	Code 3
(1st 6 mos. or lesser period)			
Do	Yes	Yes	Code 2
Do	No	Yes or No	Code 2
Limited Duty (Enl)	Yes or No	do	Code 2
(2nd and subsequent periods)			
Limited Duty (Off)	Yes or No	Yes or No	Code 2
Retain in Permanent	Yes or No	Yes or No	Code 1
Limited Duty Status (Off/Enl)			
Return to Full Duty	Yes	Not Applicable	Code 3
(Enl)			
Do	No	Not Applicable	Code 3
Return to Full Duty	Yes or No	Yes or No	Code 2
(Off)			
Discharge, EPTE Physical Disability (Off) (did not waive rights)	Yes	Not Applicable	Code 2
Do	No	Not Applicable	Code 2
Discharge, EPTE Physical Disability (Enl) (did not waive rights)	Yes	do	Code 1
Discharge, EPTE Physical Disability (Enl) (waived rights)	Yes	Not Applicable	Forward with closed Health Record after endorsement by separation activity per BUMEDINST 1910.2 series.
Discharge, EPTE Physical Disability (Off) (waived rights)	Yes	Not Applicable	Code 2
Discharge, Enlisted in Error (Recruits only)	Yes	Yes* or No	Forward with closed Health Record after separation and endorsement by recruit training facility per SECNAV INST 1910.4 series.
Do	No	Yes or No	Code 2
Discharge, Convenience of Government (Enl) ...	Yes	No	Forward with closed Health Record after endorsement by separation activity per SECNAVINST 1910.4 series.
Do	Yes	Yes	Code 2
Do	No	Yes or No	Code 2
Discharge, Convenience of Government (Off)	Yes or No	do	Code 2

Codes

- Code 1 - Forward to Central Physical Evaluation Board, Naval Council of Personnel Boards, 801 N. Randolph St., Arlington, VA 22203.
Code 2 - Forward to COMNAVMILPERSCOM or CMC via COMNAVMEDCOM (MEDCOM-25).
Code 3 - File in member's Health Record and submit availability report as required by ENLTRANS MAN.
*Yes - For consideration by the convening authority only.

18-33. Support for U.S. Coast Guard Formal Physical Disability Evaluation Board System

(1) As a consequence of the closure of Public Health Service hospitals, Navy medical support to the Coast Guard has increased. A memorandum of understanding between the Chief of Naval Operations and the Commandant, U.S. Coast Guard provides that when possible, the Navy will furnish medical support to the Coast Guard Formal Physical Disability Evaluation Board System (FPDEBS). COMNAVMEDCOM commands are expected to provide assistance to the Coast Guard, whenever possible, in the following areas:

(a) The Coast Guard requires sworn medical testimony (normally the attending physician's) to the three member FPDEBS. Any travel costs incidental to providing testimony by Navy Physicians will be borne by the Coast Guard. When the absence of the physician would cause a disruption to patient care, telephonic testimony or written dispositions are acceptable.

(b) Naval hospitals may be requested to provide physicians to participate as members of the formal panel. In that event, Formal Physical Disability Evaluation Board System sessions may be convened in the naval hospital to minimize disruption of the physician's time.

Chapter 19

FLEET MARINE FORCE

Sections	Articles
I. Departmental Responsibilities	19- 1 thru 19- 2
II. Support	19-10 thru 19-11
III. Staff Medical Officers	19-20 thru 19-23
IV. FMF Medical Organization	19-30 thru 19-34
V. Medical Augmentation of Amphibious Operations	19-40

Section I. DEPARTMENTAL RESPONSIBILITIES

	Article
U.S. Marine Corps	19-1
Bureau of Medicine and Surgery	19-2

19-1. U.S. Marine Corps

(1) *The Commandant.*—

(a) The Commandant of the Marine Corps is directly responsible to the Chief of Naval Operations for the organization, training, and readiness of those elements of the operating forces of the Marine Corps assigned to the Operating Forces of the Navy. The Commandant is responsible for planning and determining Marine Corps needs. He plans, forecasts, and determines Marine Corps requirements for equipment, material, personnel, and supporting services. In meeting these responsibilities the required medical personnel, equipment, and supplies are allocated through coordination with BUMED.

(b) Medical duties and facilities available within the Marine Corps organization are detailed in FMFM 4-5, Medical and Dental Support, U.S. Marine Corps. Additional information on the relationships between the Marine Corps and the Navy are provided in the U.S. Navy Regulations, Navy Department General Order No. 5, and the Marine Corps Manual.

(2) *The Medical Officer, U.S. Marine Corps.*—

(a) *Mission.*—The Medical Officer, U.S. Marine Corps, advises the Commandant and staff agencies on all medical service matters.

(b) *Functions.*—

(1) In coordination with the appropriate staff agencies, determines requirements for, and makes recommendations relative to, medical support assigned to the Marine Corps.

(2) Initiates action to obtain medical personnel and material to meet Marine Corps needs.

(3) Assists staff agencies in the formulation of landing force and field medical doctrines, procedures, and programs.

(4) As BUMED Code 17, Marine Corps Headquarters Liaison Officer, maintains liaison between the Commandant of the Marine Corps/Chief BUMED on all matters relating to the medical support of the Marine Corps.

19-2. Bureau of Medicine and Surgery

(1) The Fleet and Marine Corps Medical Support Division administers and coordinates all of the BUMED aspects relating to fleet and Marine Corps medical support.

Section II. SUPPORT

Medical Support	Article 19-10
Dental Support	19-11

19-10. Medical Support

(1) Medical support to the Fleet Marine Force (FMF) must satisfy three responsibilities:

(a) *The first responsibility* is to conserve the combat power of the command by a continuous and dynamic preventive medicine program and by early return to duty of patients no longer requiring medical care. Because of diversity in climates, terrain, disease vectors present, and many other factors in areas of potential Marine deployment, individual and unit preventive medicine measures are necessary at all command echelons. Supervision and technical direction of preventive medicine measures are functions of medical personnel.

(b) *The second responsibility* is to provide the best possible day-to-day care for the sick and injured. This encompasses essential diagnosis, evaluation or triage, initial medical treatment, and evacuation by means available to medical facilities appropriately situated and equipped for definitive patient care. The chain and methods of evacuation are normally as shown in figure 1 (see chap. XII, Handbook of the Hospital Corps, USN, NAVMED-P-5004, for additional casualty flow charts). However, concepts of casualty evac-

uation are subject to change with individual situations; helicopters frequently bypass the aid station and collecting and clearing companies, flying directly to the designated casualty receiving ships or to rear-area hospital installations.

(c) *The third responsibility* is medical planning in support of operations and encompasses the determination of, and formulation of plans to supply, the expected medical needs (equipment, personnel, training, and supporting services) of the FMF.

(2) Operation of medical support in the FMF is a command function. Commanders are provided medical personnel and equipment to meet this responsibility. When organic means are inadequate for a particular situation, additional medical support must be requested from the next higher echelon. Medical support is planned to conform with tactical plans and policies of the commander.

19-11. Dental Support

(1) Reference should be made to chapter 6, sections VII and XII, for information on dental support to the Marine Corps.

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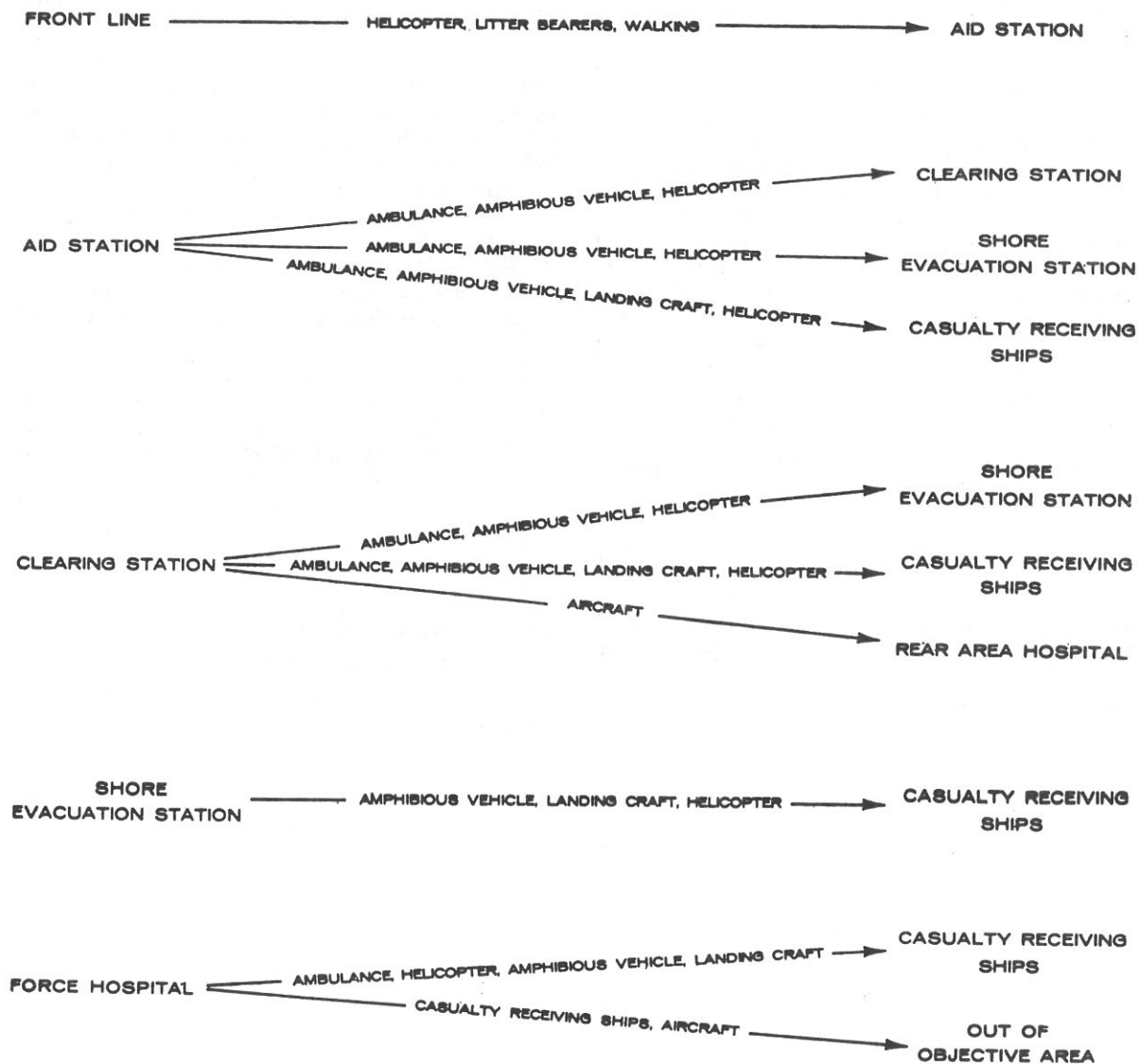


Figure 1.—Normal chain and methods of casualty evacuation

Section III. Staff Medical Officers

Force Surgeon, FMF	Article 19-20
Division Surgeon, FMF	19-21
Wing Medical Officer	19-22
Force Troops, FMF	19-23

19-20. Force Surgeon, FMF

(1) The force surgeon, FMF, advises the force commander on all medical subjects, supervises training of medical personnel and medical units, and prepares force medical plans. He also coordinates the medical service of the landing force with that of the amphibious task force, both in planning and during operations.

19-21. Division Surgeon, FMF

(1) The division surgeon advises and represents the division commander in all division medical service matters. He is a special staff officer and has no command function.

(2) He shall:

(a) Supervise all division medical activities and instruct medical personnel.

(b) Prepare division medical plans and orders.

(c) Recommend to the division commander on medical training and employment of all personnel to promote the medical welfare of the command.

(d) Advise and recommend on preventive medicine, environmental sanitation, and vector control measures, and on the care, treatment, and evacuation of the sick and wounded.

(e) Ensure that records are kept and reports made.

(f) Assign and replace medical personnel.

(g) Monitor the medical aspects of research and development.

19-22. Wing Medical Officer

(1) The wing medical officer is a special staff officer. He is a flight surgeon and, in addition to duties comparable with those of the division surgeon, has cognizance over aeromedical matters within the wing.

19-23. Force Troops, FMF

(1) The medical officer, force troops, is a special staff officer and his duties are comparable with those of the division surgeon.

Section IV. FMF MEDICAL ORGANIZATION

	Article
Medical Battalion	19-30
Group Medical Section	19-31
Squadron Medical Section	19-32
Separate Surgical Company	19-33
Hospital Company (100-Bed Field Hospital)	19-34

19-30. Medical Battalion

(1) *General.*—The medical battalion of a Marine division consists of a headquarters and service company (H&S) and four identical collecting and clearing companies. Its organization and equipment allow flexibility of employment to meet the varied and specialized conditions of an amphibious operation. Normally, one collecting and clearing company supports each regimental landing team, and the fourth collecting and clearing company and H&S company are combined to form a division hospital for support of division troops and to give depth to medical support.

(2) *Headquarters and Service Company.*—The H&S company is composed of the battalion and company headquarters, division preventive medicine section, motor transport section, medical records section, and two shock and surgical teams. The company is organized and equipped to perform administrative and service functions for the battalion.

(a) *The battalion and company headquarters* contain all the personnel necessary for the administration of the company and the battalion. The battalion headquarters includes the battalion commander, battalion executive officer, a medical administrative officer (Medical Service Corps), the division psychiatrist, an ophthalmologist, three Marine officers (the assistant to the battalion commander with additional duties as NBCD officer (S-2), battalion supply officer (S-4), and battalion motor transport officer, and the necessary Navy and Marine enlisted personnel for clerical and service duties. The battalion commander is responsible to the division commander for the training, administration, and operation of the battalion. He has additional duties as assistant division surgeon. In the latter capacity, he assists in preparation of medical plans and estimates and performs other duties assigned by the division surgeon. The executive officer assists the battalion commander in the performance of his duties and is the battalion plans and training officer. He also coordinates the evacuation of casualties, and supervises preparation of casualty and evacuation reports by the division medical records section.

(b) *Division preventive medicine section* personnel are trained in epidemiology of communicable disease, sanitation, preventive medicine techniques, and vector control measures. They are available to provide technical assistance, medical intelligence, and advice to units of the division or wing. They conduct inspections and supervise environmental sanitation, vector control, and communicable and infectious disease prevention and control. The preventive medicine officer under the division surgeon directs the activities of this section. He makes recommendations to the division surgeon regarding measures to safeguard the command against diseases common to an area or to conditions of poor sanitation and vector control.

(c) *The medical records section* consolidates information essential for the preparation of complete and accurate medical reports. This section contains enlisted clerical personnel from the battalion and company headquarters. The medical administrative officer is a Medical Service Corps officer who is an administrative specialist. He has direct supervision of the medical records section personnel.

(d) The two *shock and surgical teams*, each consisting of one general surgeon and one anesthesiologist, are used by the battalion commander to reinforce the collecting and clearing companies, as required, in response to casualty overload.

(3) *Collecting and Clearing Company.*—A collecting and clearing company consists of a company headquarters, two clearing platoons, and a collecting platoon. It is composed of 7 medical officers (1 internist, 2 general surgeons, 2 orthopedic surgeons, and 2 anesthesiologists), 1 Medical Service Corps officer, 58 hospital corpsmen, and 20 marines. The collecting and clearing company provides general treatment and holding facilities for patients who will be discharged to duty within the evacuation policy established for the beachhead. It is designed to support a regimental landing team.

(a) *Clearing Platoon.*—Each clearing platoon includes one general surgeon, one orthopedic surgeon, and one anesthesiologist, and enlisted medical technicians for ward and surgical duties. It is organized and equipped to establish and temporarily operate a 30-bed clearing

station. The clearing station receives casualties from units supported and clears them in accordance with the evacuation policy and condition of each casualty to the landing force or amphibious task force medical facilities. Personnel are prepared to perform emergency lifesaving surgery. The two clearing platoons, operating together with company headquarters, are designed for sustained independent medical action and can operate a 60-bed clearing station for an extended period. The attached marine personnel are trained in litter bearing and other casualty handling techniques.

(b) *Collecting Platoon.*—The collecting platoon is composed entirely of enlisted medical personnel. When the company operates as a unit, it is under the immediate direction of the commander of the collecting and clearing company. During the assault phase of amphibious operations, it may be attached to the regiment which is supported by the collecting and clearing company. When attached to another unit, it operates under the medical officer of the unit it supports. Personnel of the platoon collect casualties from the forward aid stations, and where appropriate, transfer them to shore or landing zone evacuation stations or to clearing stations. When the collecting and clearing companies are established ashore and after appropriate treatment has been carried out, patients will be transferred either to the beach or to a designated air facility, for further evacuation rearward. Once the collecting and clearing company is established ashore, the collecting platoon reverts to its parent medical company. Ambulances from the service section of the company headquarters operate with the collecting platoon.

(c) Guerilla type warfare and ample helicopter support may result in the collecting and clearing companies functioning as a division hospital farther to the rear of the actual combat and patrol areas.

19-31. Group Medical Section

(1) The group medical section is attached to the Marine airbase squadron. Sufficient personnel are authorized to operate a 20-bed medical-surgical facility. Each Marine wing support group has adequate medical personnel in its headquarters and maintenance squadron to care for group personnel plus personnel of Marine aviation units operating from the airbase which are not authorized medical sections. There are no specialists assigned to a wing in peacetime. Therefore, to make an average wing combat ready, eight specialists (four general surgeons and four anesthesiologists) are required. Personnel requiring ex-

tensive surgery or hospitalization must be evacuated to supporting force units, division units, or facilities afloat.

19-32. Squadron Medical Section

(1) Squadron medical sections are authorized for separate tactical squadrons such as VMA (Attack, Jet Aircraft), HMR (Helicopter), VMGR (Transport). These are small, usually consisting of one flight surgeon and three to four hospital corpsmen, and are capable of conducting routine sickcall as well as aviation medical functions.

19-33. Separate Surgical Company

(1) The separate surgical company is an FMF unit which may be attached to a large force for amphibious operations. It is relatively immobile and designed for operation in an advanced base either as a single unit, or with less capability, as two separate units. It consists of a headquarters platoon, a hospital platoon, and a service platoon. It has the staff and equipment to operate a 400-bed hospital. Included in this staff are 21 medical officers, 2 dental officers, 3 Medical Service Corps officers, 2 chaplains, 148 hospital corpsmen, 4 dental technicians, 2 Marine Corps officers, and 80 enlisted marines.

(2) In the early stages of an amphibious operation, portions of this company may be organized into six teams for duty on casualty receiving ships.

(3) When the tactical situation permits, the company establishes a hospital, but not as a normal echelon in the chain of evacuation. This hospital provides highly specialized surgical facilities including maxillofacial and oral surgeons. Casualties requiring such facilities are routed to it from collecting and clearing companies, or from the force hospital company. Upon discharge, patients reenter the normal chain of evacuation.

(4) Elements of the company may also be attached to a division when the division operates independently.

19-34. Hospital Company (100-Bed Field Hospital)

(1) The hospital company consists of a company headquarters and a hospital platoon. The company includes seven medical officers; i.e., two general surgeons, one orthopedic surgeon, one anesthesiologist, one internist, and two general practitioners. In addition, there are 1 Medical Service Corps officer, 60 hospital corpsmen, and

31 enlisted marines. This hospital company provides additional hospitalization facilities ashore for casualties who are not evacuated to amphibious task force medical facilities afloat. This is

necessary when the tactical situation or other conditions prevent evacuation to amphibious task forces facilities or when additional hospitalization is required for casualty overflow.

Section V. MEDICAL AUGMENTATION OF AMPHIBIOUS OPERATIONS

19-40. Augmentation Personnel and Materiel

(1) BUMED has assigned certain naval hospitals the responsibility for sponsorship of surgical teams, surgical support teams, FMF surgical platoon cadres, and other special teams. BUMED-

DINST 6440.1 series prescribes the function, composition, activation, deployment, and material support of these teams; and outlines the procedures governing their organization, administration, and training.

Chapter 20

RESEARCH AND DEVELOPMENT

Sections

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20-1. Policy

(1) The fundamental policy of the Navy Medical Department encourages and supports research and development (R&D) in medical, dental, nursing, and allied sciences. This R&D is directed at the solution of problems affecting the health, safety, selection and efficiency of Navy and Marine Corps personnel.

20-2. Departmental Responsibilities

(1) General.-The Assistant Secretary of the Navy for Research, Engineering and Systems (ASN (RE&S)), under direction of the Secretary of the Navy, exercises responsibility for Department-wide supervision of all research, development, engineering, testing, evaluation of efforts, and appropriations management. The principal advisors for support and assistance are: The Director of Research, Development, Test and Evaluation (RDT&E) for the Chief of Naval Operations; the Deputy Chief of Staff, Research, Development and Systems (RD&S), Marine Corps; the Chief of Naval Research; the Chief of Naval Technology; the Commander, Naval Medical Command; and SECNAV-Designated Project Managers. The interpretation and promulgation of DOD policies and procedures by the Secretary of the Navy or ASN (RE&S) provide the framework for planning and implementing the RDT&E program. Full responsiveness of the RDT&E program to Navy needs is ensured through the coordination of the above principal advisors (SECNAVINST 5430.67 series).

(2) Medical Department.- Under the policy guidance of the Director, Naval Medicine and the direction of the Naval Medical Command, the management and coordination of the RDT&E programs of the Medical Department of the Navy are the responsibility of the Naval Medical Research and Development Command (NMRDC).

(3) Naval Medical Command.

(a) The Deputy Commander for Fleet Readiness and Support is responsible for the overall management of Research and Development matters. The Naval Medical Command:

(1) Identifies, defines, and communicates requirements for medical RDT&E consistent with higher authority.

(2) Assesses and oversees the RDT&E programs to ensure responsiveness to defined requirements.

(3) Monitors and coordinates Medical Department responsibilities concerning the use and protection of human subjects utilized in studies conducted under the auspices of the Department of the Navy.

(4) Exercises command responsibility over the Naval Medical Research and Development Command.

(4) Naval Medical Research and Development Command (NMRDC).-

(a) The Commanding Officer of the Naval Medical Research and Development Command serves as an advisor to the Director, Naval Medicine and Commander, Naval Medical Command.

(b) The direct management and coordination of the Navy Medical Department RDT&E program is carried out by the Naval Medical Research and Development Command.

The Naval Medical Research and Development Command:

(1) Commands and provides mission support for the Navy Medical Department research and development laboratories and activities.

(2) Directs, plans, programs, budgets, and documents Navy Medical Department RDT&E efforts in response to Navy and Marine Corps RDT&E requirements.

(3) Recommends the qualifications, procurement, training, assignment, and distribution of research and development personnel.

(4) Provides professional medical and dental technical guidance in the planning of Navy and Marine Corps RDT&E on weapons systems, life support systems and personnel protection.

(5) Coordinate research efforts with other Navy commands and offices, other Government agencies, civilian organizations, and foreign governments.

20-3. Scope

(1) Medical Department research and development programs shall be organized to support Navy, Marine Corps, and Medical Department missions and shall be directed toward improving and protecting the health and performance effectiveness of Navy and Marine Corps personnel in operational environments.

(2) Medical Department research, development, testing, and evaluation (RDT&E) shall address medical requirements promulgated by the Chief of Naval Operations, the Commandant of the Marine Corps, the Chief of Naval Research and the Chief of Naval Technology, following validation by the Director, Naval Medicine. To meet these requirements and objectives, a broad program of RDT&E shall be maintained in the basic and applied sciences, with major emphasis placed on problems of combat casualty care, performance effectiveness, decompression sickness and diver health, disease prevention and control, and occupational hazards in naval environments.

20-4. Professional Personnel Assignments

(1) The Navy Medical Department sponsors research programs in aviation medicine, diving medicine, submarine medicine, fleet health care, fleet occupational health, infectious diseases, oral and dental health, human performance, and electromagnetic radiation. Research efforts under these programs are conducted at U.S. Navy medical research laboratories located within the contiguous U.S., as well as at selected overseas locations. Personnel of the Medical Corps, Dental Corps, Medical Service

Corps, and Nurse Corps are encouraged to contact their appropriate detailers regarding assignment possibilities within the Navy biomedical research and development community. Qualified personnel will be given guidance and aid in securing assignments, contingent upon availability of billets and requirements in given programs.

20-5. Program Management

(1) Structure.-The technical and administrative management of medical RDT&E is accomplished within the planning, programming, and budgeting system. Under this system, RDT&E is categorized under DOD Program VI, Research and Development, and is divided into five broad categories: 1-Research, 2-Exploratory Development, 3-Advanced Development, 4-Engineering Development, and 5-Management and Support.

(2) Categories.- Programs are conducted under the following categories:

(a) Category 1, Research, includes efforts directed toward enhanced knowledge of medical and behavioral sciences, and the solution of problems associated with these sciences. It provides the base for subsequent exploratory and advanced development.

(b) Category 2, Exploratory Development, includes efforts directed toward the solution of specific military problems, short of major development projects. This type of effort may vary from fundamental applied research, to minor development efforts. The dominant characteristic of this category is that it addresses specific military problems with a view toward developing and evaluating the feasibility and practicability of proposed solutions.

(c) Category 3, Advanced Development, includes efforts relating to the design of equipment, materials, or procedures for subsequent test and evaluation, but does not necessarily assure their operational usefulness, technical feasibility, or financial acceptability.

(d) Category 4, Engineering Development, includes those projects being engineered for service use but that have not yet been approved for procurement or operation. Efforts in this category will include a determination of operational usefulness, acceptability, and cost.

(e) Category 5, Management and Support, provides facilities and installation support for research and development activities, and managerial and planning support at NMRDC. This category provides funds for the indirect cost of research and development and other laboratory costs not directly related to specific research efforts. Included are costs for operation and maintenance, minor

construction and alteration, administrative support, and general purpose scientific equipment.

(3) Projects and Task Areas.- Projects, task areas, and tasks for medical RDT&E will be established in a manner consistent with the requirements specified in paragraph 20-3(2) above.

(4) Work Units.-Work units under the above projects, task areas, and tasks will be assigned either to activities directly by NMRDC or as approved research and development proposals submitted by the activities.

(a) Proposals for Navy medical RDT&E support shall be submitted to NMRDC by the performing activities.

(b) Proposals shall be submitted on the Research and Technology Work Unit Summary, DD Form 1498, in accordance with DOD Directive 3200.12 series and annual implementing guidance provided by NMRDC.

(c) The selection and approval of medical RDT&E proposals will be based on program objectives and operational requirements, immediacy of need, operational impact, experience and competence of the investigators, scientific merit, availability of facilities and funds, and probability of success, level of effort outside the Navy, and the special opportunities that may be offered by the location and environment of particular facilities. Programs are reviewed systematically by in-house scientific advisory committees and NMRDC program managers, and by the Joint Technology Coordinating Groups of the Armed Services Biomedical Research Evaluation and Management Committee. A variety of ad hoc mechanisms are also employed, including but not limited to external peer review groups, technical workshops and program or resources sponsor reviews.

(5) Reporting Requirements.-

(a) Management Reports.-NMRDC requires regular progress reports on work units under its management responsibility. Interim progress reports are required annually on all active work units. Final reports are required at the earliest practicable time on completion or termination of work units.

(b) Technical/Scientific Reports.-

(1) In accordance with SECNAVINST 3900.29 series, a DD Form 1473, Document Control Data-R&D, shall be completed and included as the last page of each copy of all technical/scientific reports, including those submitted in reprint form. The instruction sheet that is attached to DD Form 1473 should be consulted for information about preparation of the form.

(2) Twelve copies of unclassified technical/scientific reports shall be submitted to the Defense Technical

Information Center (DTIC) accompanied by a DTIC Form 50. All copies of reports submitted shall include an appropriate distribution statement in accordance with NAVMATINST 5200.29 series. Three copies of all technical/scientific reports shall also be submitted to NMRDC. Reproduction of published articles will conform to existing Federal copyright laws and regulations.

(3) Technical/scientific reports shall be classified in accordance with OPNAVINST 5510.1 series, Department of the Navy Information Security Program. A recommended distribution list for each classified report shall be submitted to NMRDC for review and approval prior to distribution.

(4) To ensure uniform compliance with established Navy policy and security regulations, all medical R&D technical/scientific reports, speeches, and any other material planned for public dissemination, shall be cleared by the commanding officer of the performing activity and should be consistent with current guidance provided by article 1116 of NAVREGS and OPNAVINST 5510.1 series in reviewing material for public disclosure. If a clearance determination cannot be made at the command level, the material should be submitted to NMRDC for review and decision.

20-6. Independent Research Program

(1) Objective.-The principal objective of this program is to enable laboratories to expand basic research capabilities. Through this program, highly competent investigators are encouraged to initiate new and challenging work that may ultimately enhance regular laboratory programs or lead to innovative long-term efforts.

(2) Funds.-Subject to the current availability of funds, NMRDC will provide Navy medical RDT&E laboratories with funds to conduct independent research. These funds, being allocated in addition to those used to support other approved or assigned work units, will provide flexibility for the investigation of new ideas generated during the year. Primarily, independent research funds are to augment technical competence and be used for work that has clear Navy relevance. These funds shall not be used to compensate for other approved programs' deficits or as a substitute for previously rejected research proposals.

(3) Controls.-NMRDC approval is required for research undertaken with these funds, but projects are initiated by investigators and should address innovative new work that has Navy relevance. This research must conform to the policy guidance indicated in (20-7) and (20-8).

Research projects will have a 3-year limitation, after which the research will be considered completed, terminated, or appropriate for funding in other research programs.

(4) Management Reports.-Annual progress reports on work sponsored under the Independent Research Program shall be submitted in accordance with NAVMATINST 3920.3 series and specific guidance issued annually by NMRDC. A DD 1498 ("NEW") will be forwarded to NMRDC for assignment of a work unit number and submittal to the Defense Technical Information Center.

20-7. Use of Human Volunteers in Medical Research

(1) Authority.-SECNAVINST 3900.39 series prescribe Navy policies and procedures governing the use of human volunteers in RDT&E projects. These instructions shall be followed for any medical research and development efforts involving use of human volunteers.

(2) Records.-Medical research documentation and records must be filed and retained in accordance with the provisions of SECNAVINST 3900.39 series.

20-8. Use of Animals in Medical Research

(1) Authority.-DOD Directive 3216.1 series and implementing SECNAVINST 3900.38 series establish policies and procedures governing the responsible use, humane care, and review of the use of animals in RDT&E programs. These instructions shall be followed for any biomedical research and development efforts involving the use of animals.

(2) Personnel and Technical Assistance.-BUMEDINST 6401.1 series delineates the policies governing military veterinary medical support for Naval activities. SECNAVINST 3900.38 series assigns NAVMEDCOM the responsibilities of coordinating and overseeing the use of animals by the Naval Establishment, and the Assistant for Veterinary Medicine (Code 02E) NAVMEDCOM, will provide specialized assistance as needed.

20-9. Use of Investigational Items Under Federal Food and Drug Administration Control

(1) Authority for Navy Medical Department activities or contractors supported by the Navy Medical Department to conduct clinical, laboratory, or field trials of drugs or biologicals covered by the Federal Food, Drug, and Cosmetic Act must be obtained from NAVMEDCOM in accordance with the provisions of NAVMEDCOMINST 6710.4 series.

(2) Compliance with SECNAVINST 3900.39 series is also required when human volunteers participate in Navy Medical Department-sponsored RDT&E investigations using FDA-controlled materials.

20-10. Resident Associateships

(1) NMRDC, in cooperation with the National Research Council, National Academy of Sciences, and the National Academy of Engineering, offers numerous opportunities for postdoctoral research to qualified civilian biomedical scientists and bioengineers in areas of major concern to the scientific and technological community. Within the fields of aerospace, submarine, diving, preventive medicine, oral health, and the behavioral sciences, NMRDC scientists seek to define potential medical hazards facing man in naval systems, and to devise methods and procedures to counteract them; thus ensuring maximum effectiveness in underwater, surface, and aerospace environments.

(2) Resident Research Associateship awardees may be offered appointments by the National Research Council (NRC). Award applications will be received by the NRC Associateship Office and evaluated on a competitive basis by special NRC panels of scientists and engineers. Each applicant is responsible for formulating a specific research plan on a problem related to NMRDC current program interest, and which program the applicant wishes to investigate. Individuals having research interests relating to one or more of the opportunities described in this chapter are advised to communicate directly with NMRDC for further information.

Chapter 21

PHARMACY OPERATION AND DRUG CONTROL

Sections

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Section I. PHARMACY ADMINISTRATION

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21-1. Facilities (Regulatory)

(1) Naval medical facilities dispensing drugs range from large medical centers to support stations aboard the ships of the fleet and ashore. The overall mission of each facility will determine the type of pharmacy personnel assigned and the drugs to be stocked.

21-2. Personnel (Regulatory)

(1) Pharmacists, graduates of accredited pharmacy colleges and registered in one of the United States, should be assigned duty at all large military pharmacies at fixed treatment facilities filling more than 5,000 drug prescriptions per quarter in the U.S. and facilities outside of the U.S. where a major proportion of the workload involves the filling of prescriptions for civilian personnel and military dependents.

(2) Activities not having an allowance for military pharmacy officers but which require the services of pharmacists, and those activities which have an allowance for pharmacy officers but require additional

pharmacists shall request consideration of necessary funds and ceiling for employment of civilian pharmacists.

(3) At other activities where the use of a full-time pharmacist would not be justified, pharmacies may be operated (a) on a part-time basis by officers who are pharmacists but who are assigned other primary duties, or who cover a number of such facilities, (b) by part-time civilian pharmacists or, (c) by dispensing physicians.

(4) Pharmacy technicians may continue to operate facilities dispensing less than 5,000 drug prescriptions quarterly, and shall be under the cognizant responsibility of a pharmacy officer or dispensing physician, except as outlined in section IV.

(5) In general, positions for pharmacists in pharmacies outside the U.S. shall be filled with experienced, commissioned military pharmacists who will rotate with pharmacy officers stationed in the U.S.

(6) Every effort shall be made to provide the opportunity for all pharmacy staff to update and increase their knowledge of the drugs they dispense.

21-3. Responsibilities (Regulatory)

(1) The senior pharmacist, dispensing medical officer, pharmacy technician, or Hospital Corps member in charge shall be responsible to the commanding officer for proper storage and dispensing of the drugs in custody and shall carry out correct recordkeeping and reporting of such functions.

21-4. Prescribers (Regulatory)

(1) Authorized prescribers shall include: officers of the Medical and Dental Corps, Medical Service Corps podiatrists, civilian physicians employed by the Navy, independent duty Hospital Corps personnel authorized in section IV, and others authorized to write prescriptions in their official capacities. Qualified nurse practitioners and physician's assistants may write prescriptions in accordance with article 21-4(3). Qualified nurse anesthetists and midwives may be authorized in writing by the commanding officer or the CO's delegated representative to prescribe on inpatient records as required within the scope of their practice.

(2) Prescriptions written by civilian practitioners, other than those employed by the Navy, will be filled for authorized personnel and their dependents consistent with policies for prescriptions written by military prescribers. Such prescriptions must comply with the command's policies applicable to military practitioner prescriptions. This includes conformance with the MTF's formulary, quantity restrictions, refill limitations, or any other requirement placed on the military practitioners' prescriptions. Providing the MTF's written pharmacy policy and formulary to the civilian practitioners is a means which may be used to improve pharmacy service to outpatients. Civilian practitioners' prescriptions are not to be countersigned or rewritten by Medical Department personnel.

(3) Qualified military nurse practitioners and military physician's assistants may write prescriptions when authorized in writing to do so by the commanding officer. They shall prescribe those drugs and quantities approved by the commanding officer on recommendation by the Pharmacy and Therapeutics Committee. Mentors for these prescribers shall review their prescriptions at frequent intervals to assure rational prescribing.

(4) Authorized prescribers are prohibited from prescribing controlled medications listed in schedules II through V for themselves and their family members. (See art. 21-20(2) for description of various schedules of drugs.)

(5) Pharmacies shall maintain a file of sample signatures for all staff practitioners authorized to provide care.

Practitioners not on the staff of the medical or dental treatment facility (i.e., a civilian community practitioner or a military practitioner attached to a separate command) whose prescriptions can be filled at the medical or dental treatment facility pharmacy, will not be required to provide a signature card. However, a means of identifying the non-staff practitioner shall be available for the evaluation of the prescription. This requirement can be met by obtaining State or county medical or dental society directories or directories of other appropriate organizations.

21-5. Outpatient Prescription (Regulatory)

(1) Authorized prescribers working for or serving in the Navy, as outlined in article 21-4, shall use the DOD Prescription (DD Form 1289) or Polyprescription (NAVMED 6710/6). Special provisions for Hospital Corps personnel on independent duty are in article 21-50(10). Prescriptions will be acceptable when written by authorized prescribers on prescription forms authorized by other services and forms conforming with State pharmacy laws from civilian physicians. Retired military physicians may use the DD 1289 to write prescriptions for personal use only. Qualified military nurse practitioners, military physician's assistants, and others authorized in writing by the commanding officer to write prescriptions, will not write their prescriptions on the same DD 1289 used by other practitioners, but will use a color coded facsimile which bears a statement indicating that such a prescription can be filled at the originating command only.

(2) Prescriptions shall be written in black or blue-black ink, indelible pencil, or typewritten and must show the following:

- (a) The full name of the patient.
- (b) Date the prescription was written.
- (c) Patient's age (if 12 years or younger).
- (d) Full name of drug, form of drug, dosage size or strength written in the metric system, and quantity to be dispensed (such quantities as one bottle will not be acceptable). Do not use abbreviations. Prescriptions should be written generically.

(e) Complete directions for the patient (such expressions as "take as directed," "label," etc. are not considered adequate directions).

(f) Signature of prescriber (full name).

(g) See article 21-27 for additional requirements when prescribing controlled substances.

(3) Proper labeling of outpatient prescriptions shall be observed at all times. The following elements shall be included:

(a) Heading of label identifying the facility filling the prescription, including a telephone number of the pharmacy.

- (b) Identifying consecutive number.
- (c) Full name of patient.
- (d) Date prescription filled.
- (e) Directions to the patient which are definite and concise.
- (f) Full name of drug, strength, and doses dispensed.
- (g) Name of prescriber.
- (h) Initials of typist.
- (i) Indication of refills.
- (j) Expiration date, if applicable.
- (k) Proper auxillary labels as indicated.

(4) Telephone or oral prescriptions, except in an emergency, will not be accepted. Emergency prescriptions shall be reduced to writing as soon as possible following the emergency.

(5) Prescriptions shall be personalized. If more than one member of a family is prescribed the same drug, a separate prescription blank should be used for each member.

(6) Prescriptions for animals other than those owned by the Government will not be filled.

(7) Prescriptions will not normally be dispensed by mail. This does not preclude an exception to be made with prior approval by the commanding officer.

(8) Adequate records shall be maintained to permit recall of drugs dispensed in event of a Food and Drug Administration recall. This may include recording the manufacturer and lot number on each prescription, maintaining a log book for each item stocked indicating manufacturer, lot number, and date placed in service, or any other suitable method.

(9) All controlled drugs prescribed, including those for medical staff members, shall be annotated in the member's Health Record at the time they are prescribed. Health Records of medical staff members shall be audited periodically to assure that entries have been made to substantiate prescriptions written.

(10) Except in extraordinary situations, practitioners may not prescribe controlled medication to patients who are not under their direct care.

(11) When an eligible patient is accepted at one of COMNAVMECOM activities providing outpatient treatment, the necessary drugs to support the treatment shall be dispensed at no cost to the individual.

(12) In MTF's that do not have an assigned pharmacist, generic substitution of a formulary item for non-formulary items can be made only if approval is obtained from the prescriber. Phone confirmation is adequate. The prescription will be annotated as to the date that the prescriber was contacted, name of the medication to be substituted, and the name of the individual making the substitution.

(13) Except in command approved programs, outpatient medications will be dispensed only on receipt of a valid prescription, see article 21-4(2) and 21-5(1). In a command approved program medications may be dispensed, after appropriate medical evaluation, from a health record entry. A specific protocol must exist for the program and the list of medications must have been reviewed by the Pharmacy and Therapeutics Committee and approved by the commanding officer.

21-6. Inpatient Dispensing (Regulatory)

(1) The primary means of inpatient drug distribution in inpatient treatment facilities shall be the unit dose system which shall include the pharmacist interpreting the physician's order and monitoring inpatient medication needs.

(2) Periodic checks shall be made by the pharmacy at least monthly of all ward and clinic drug storage spaces to reduce overstocking and to assure that such items are not outdated.

(3) All drug orders for narcotics, sedatives, hypnotics, anticoagulants, and antibiotics shall be automatically discontinued after 48 hours unless: (a) the order indicated an exact number of doses to be administered, (b) an exact period of time for medication is specified, or (c) the attending physician or dentist reorders the medication.

(4) The pharmacy is responsible for labeling of medications. All medications issued in bulk containers to wards or clinics shall be labeled with the date of issue, generic and trade name, strength, quantity, expiration date, name of the manufacturer, and lot number or appropriate code to identify the drug.

(5) Drug issues to clinic for subsequent reissue to outpatients shall be adequately labeled in the pharmacy. Elements (a), (e), (f), and (j) of article 21-5(3) shall be included on the label in the pharmacy or shall be added in the clinic.

21-7. Drug Stock (Regulatory)

(1) It is imperative that personnel handling drugs understand their actions, know the dosage range, and contraindications. Every effort shall be made to furnish continuing education necessary to provide knowledge to those responsible for dispensing drugs.

(2) The Defense Stock System is in existence to serve the needs of the Medical Department and should be the backbone of drug stock and supply in any Navy medical facility.

(3) Only those items which have been licensed and approved by the Food and Drug

Administration for sale in the U.S. are authorized for use in naval medical facilities.

(4) Investigational drugs shall be stored and processed through the pharmacy service as outlined in NAVMEDCOMINST 6710.4 series.

(5) Caustic acids such as glacial acetic, sulfuric, nitric, concentrated hydrochloric, or oxalic acid shall not be issued to wards or outpatients but shall be stored in separate lockers, clearly marked as to contents. Methyl alcohol shall not be stored, used, or dispensed by the pharmacy.

(6) Flammable drugs shall be stored in accordance with accepted fire safety regulations.

21-8. Antidotes and Antidote Lockers (Regulatory)

(1) All Medical Department personnel shall be trained regarding the dangers of poisons and the use of antidotes.

(2) A separate poison antidote locker marked ANTIDOTE LOCKER shall be located prominently in every emergency room. If necessary, more than one locker may be used. (On small ships that have only one

independent duty Hospital Corps member aboard, the locker shall be located immediately outside the emergency treatment room for ready accessibility when such member is absent.) The locker shall be secured with a breakable seal. Whenever the seal is broken, the contents shall be inventoried, the used antidotes replaced, and the locker resealed. An alphabetical inventory list designating shelf location shall be on the inside of the door and a copy displayed outside together with a copy of NAVMED P-5095 (Poisons, Overdoses, and Antidotes) and the address and telephone number of the local poison control center where applicable. The locker shall contain at least the antidotes listed in NAVMED P-5095, and only the supplies and instruments required for treatment of poisoning and overdoses. All personnel participating in emergency room treatments shall be thoroughly familiar with the contents of the locker and their use. The books, Clinical Toxicology of Commercial Products by Gleason, Gosselin, Hodge, and Smith and Handbook of Poisons by Robert H. Driesbach, M.D. are recommended as reference material and should be outside the locker for easy reference.

Section II. CONTROLLED SUBSTANCES

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21-20. General (Regulatory)

(1) Controlled substances, as used herein, are those drugs scheduled in the Controlled Substance Act of 1970 (Public Law 91-513) and alcohol.

(2) There are five schedules designated by section 20-2, part 308 of the Federal Act: schedule I—drugs with no acceptable drug use but maximum abuse potential; schedule II—drugs having an acceptable drug use and a very high abuse potential; and schedules III, IV, and V—drugs having acceptable drug use which are considered to have lessening degrees of abuse potential. Products may migrate between schedules, and new products may be added. These changes shall be promulgated by the Navy Medical and Dental Material Bulletin.

(3) It is the prerogative of the local command to designate certain drugs as having abuse potential and require any security measures similar to controlled substances procedures.

(4) Alcoholic beverages shall not be stocked or dispensed from Navy medical facilities.

21-21. Accountability (Regulatory)

(1) Schedules I and II drugs, schedule III narcotics, and alcohol require vault/safe storage and monthly inventory by the Controlled Substances Inventory Board (as outlined in art. 21-24). Working stock may be kept in a locked area within the pharmacy. A copy of the safe combination shall be kept in a sealed envelope deposited with the commanding officer or representative.

(2) Schedules III (less narcotics), IV, and V drugs require locked cabinet security for storage of bulk drugs. A minimum amount of working stock may be dispersed among other pharmacy stock provided the pharmacy itself is secure. Otherwise, all stock in this category shall be kept in locked cabinet security. Inventory shall be by the custodian biennially on a Controlled Substance Inventory List form provided by the Drug Enforcement Agency and in accordance with their directions.

21-22. Prescribing (Regulatory)

(1) All prescribers authorized in section I shall prescribe controlled substances only on the DD 1289, or color coded facsimile if appropriate.

(2) Authorized prescribers, when prescribing in an official capacity drugs within the scope of the Controlled Substances Act, are exempt from registration under provision of section 301.25 of the Act. The officer's social security number (SSN) shall be used in lieu of the registration number normally required on civilian prescriptions. This exemption does not apply when the officer renders professional treatment outside official duties. In such event, the prescriber is required to register, at no cost to the Government, and in all other respects comply with the provisions of the law and regulations governing private practice.

(3) An officer or civilian physician employed by the Navy who has been designated by a command to purchase or procure from commercial sources controlled substances or preparations for official use shall be so designated on the command's registration which is filed with the Registration Branch, Drug Enforcement Administration, Department of Justice, Washington, D.C. 20537. Only individuals so designated may sign the official order form for controlled substances. Government registration is for 1 year, but individuals designated may be changed by letter to DEA, signed by the commanding officer.

(4) Military nurse practitioners and physician's assistants shall not prescribe controlled drugs listed in schedule II or schedule III narcotics. Authority for nurse practitioners and physician's assistants to prescribe all other controlled drugs will be designated in writing by the commanding officer specifying the limitations to be followed.

21-23. Custody (Regulatory)

(1) Stocks of controlled substances and alcohol carried in the Navy Stock Account, located at wholesale stock points, Navy retail stock points, and mobile logistic support ships are not within the scope

of this article. Procedures for handling stocks of these special materials at such activities are promulgated by the Naval Supply Systems Command manuals and directives. All quantities of controlled substances and alcohol issued to use shall be managed in accordance with this chapter and current instructions as applicable.

(2) Custodial responsibility for controlled substances, alcohol, and dangerous drugs shall be vested in a commissioned officer, appointed in writing, except remote branch clinics which have no officers assigned. In such instances, the commanding officer shall designate a member of the branch clinic as custodian.

21-24. Security (Regulatory)

(1) Schedules I and II drugs, schedule III narcotics, and alcohol require special handling and accounting to provide adequate protection against drug abuse, carelessness, theft, and misappropriation. Accordingly, the following measures, in addition to those prescribed elsewhere in this chapter, shall be enforced in all activities except stock points of the medical and dental supply system. The security measures for handling material at medical and dental stock points are included in the NAVSUP manuals and current directives.

(a) The person having custody of the schedules I and II drugs, schedule III narcotics, and alcohol shall assure, by physical inventory, that all quantities received and expended have been properly accounted for. The frequency of such custodians accounting should be guided by the transaction frequency but should be checked at least weekly.

(b) Monthly or more frequently, if necessary, inventory of schedules I and II substances, schedule III narcotics, alcohol, and those drugs designated by local command shall be made by the Controlled Substances Inventory Board appointed in writing by the commanding officer. The Controlled Substances Inventory Board shall be composed of three members, at least one of whom shall be a commissioned officer. Senior enlisted personnel in pay grades E-7 through E-9 may serve as members at the discretion of the commanding officer. Additional members may be appointed as outlined in article 21-29. The senior officer assigned to the Board shall be designated as the senior member. At least one officer of the Board shall be an officer of the Medical, Dental, Medical Service, or Nurse Corps except when not available. No member of the Board may be directly responsible for the substances being inventoried. A sample of all prescribed accounting records and prescriptions for these substances for the prescribed period shall be checked for compliance with regulations, particularly as to dating, proper preparation, and required signature. The Board shall ensure that the records inspected constitute a complete audit trail and that they reflect transactions which have occurred during

the accounting period. Pharmacy stock and perpetual inventory records, requisitions, receipts, and issue documentation shall be audited. The identity of any questionable items of inventoried stock should be ascertained. Supply department records should be checked as required to verify that all documents are accounted for. For this purpose, the supply department is to provide directly, to the senior member of the Board, a copy of all issue documents for schedules I and II controlled substances, and schedule III narcotics and alcohol.

(c) See article 21-47 concerning the Controlled Drug Inventory Report.

21-25. Reporting Theft or Loss (Regulatory)

(1) The Drug Enforcement Agency (DEA) regulations require that notification be made to the nearest DEA Regional Office upon the discovery of theft or significant loss of any controlled substance. The theft or loss shall be reported immediately, using Report of Theft of Controlled Substances (DEA Form 106) (original and 3 copies). Send the original and one copy to the nearest DEA Regional Office, one copy to BUMED (MED 27), and one copy to the nearest field representative of the Naval Investigative Service. (If the controlled substances are stolen or lost in transit, the consignee shall submit a sworn statement of facts with the DEA Form 106.)

(2) Losses of alcohol because of breakage, theft, or irreconcilable differences shall be reported to the commanding officer by the Controlled Substances Inventory Board in the monthly Controlled Drug Inventory Report.

21-26. Deterioration (Regulatory)

(1) Schedules I and II controlled substances, schedule III narcotics, alcohol, and locally controlled drugs which have deteriorated and are not usable, are of questionable purity or potency, or have had their identity compromised, shall be reported to the commanding officer. If destruction is indicated and directed by the commanding officer, destruction shall be accomplished in the presence of a member of the Controlled Substances Inventory Board. A certification shall include the complete nomenclature and quantity of the substances to be destroyed together with the method to be used to accomplish destruction. After certification is completed, approved by the commanding officer, and signed by the members witnessing destruction, the certification shall be retained in the files as authority for dropping the items from the appropriate record. Notification of the Drug Enforcement Agency (DEA) is not necessary.

21-27. Dispensing by Pharmacy (Regulatory)

(1) The pharmacy shall serve as the source from which wards, clinics, and other departments of a

facility shall normally obtain controlled substances and alcohol for use in connection with the treatment of patients. Authorized outpatient prescriptions for controlled substances must be filled by the pharmacy. Alcohol may be issued directly to the laboratory providing such stocks are included in the monthly audit conducted by the Controlled Substances Inventory Board.

(2) Controlled substances shall be dispensed to outpatients on receipt of a prescription completed in accordance with article 21-22 with the following additional requirements:

(a) The complete address of the person for whom the prescription is written (may be supplied by patient or agent at time of filling).

(b) The legible, legal signature, social security number, and service of the prescribing Medical Department member as authorized in article 21-4. In addition, the name of the prescriber must be stamped, typed, or handprinted on the prescription.

(c) Erasures or interlineations on prescriptions for controlled substances are prohibited unless initialed by the prescriber.

(3) Prescriptions for schedule II controlled substances and schedule III narcotics shall not be refilled.

(4) Prescriptions for schedule II controlled substances, schedule III narcotics, and alcohol at the time of filling shall be dated, numbered, and signed by the dispenser across the front of the prescription. The reverse side of the prescription shall include the wording "received by" in addition to date, address, and signature of the recipient of the drug item.

(5) A separate prescription file shall be maintained for prescription records of schedule II controlled substances and schedule III narcotics.

(6) Prescription records of controlled substances listed in schedules III (other than narcotics), IV, and V shall be maintained separately from all other records of the pharmacy.

(7) Alcohol is managed the same as a controlled substance. Prescriptions for this substance shall be given a separate serial file number preceded by "A" and shall be filed separately from all other prescriptions.

(8) Prescriptions for schedule II drugs, schedule III narcotics, and alcohol used in bulk compounding of pharmaceuticals shall be signed by a medical officer designated by the commanding officer. Normally, the designee will be the director of clinical services.

(9) Dispensing of schedule II controlled substances, schedule III narcotics, and alcohol to wards and clinics shall be accompanied by and in consonance with the system of forms as outlined in section III.

(10) Controlled substances shall be dispensed with labels affixed according to guidelines set down in section I. In addition, controlled substances dispensed to wards and clinics shall identify the DEA schedule on the label.

21-28. Control by Nursing Units and Clinics (Regulatory)

(1) To provide effective and adequate controlled substance protection, the following measures of control shall be enforced:

(a) A registered professional nurse or medical officer will be charged with custodial responsibility for controlled substances in accordance with this article and other directives that may be issued.

(b) No registered professional nurse or medical officer charged with custodial responsibility of these substances, shall permit any such substances to be placed in the possession of other personnel in quantities greater than the amount required for immediate consumption by the patients.

(c) The professional nurse or medical officer to whom such items are issued shall maintain a locked container, cabinet, or compartment of an approved nature in which such substances shall be kept. Keys to such containers will remain in the custody of the nurse or medical officer responsible and transferred only to another authorized professional.

(2) Each ward, clinic, or other activity drawing controlled substances from the pharmacy shall maintain a looseleaf notebook containing the Narcotic and Controlled Drug Inventory-24 Hour (NAVMED 6710/4) and the Narcotic and Controlled Drug Account Record (NAVMED 6710/1) in accordance with article 21-42.

(3) Controlled substances may be ordered from the pharmacy on any suitable form approved by the local command and may be signed by an authorized official in accordance with article 21-4 or by the ward charge nurse. The supply of controlled substances to wards and clinics may also be accomplished by a replenishment system, not requiring a signed form, but automatically replacing deleted stock at a set level.

(4) The delivery of controlled substances from the pharmacy to various charge nurses or medical officers shall be made by pharmacy only.

(5) Upon receipt of these substances from the pharmacy, the charge nurse or medical officer shall check the amount of drug, and compare the serial numbers on the NAVMED 6710/1 and the prescription. If a discrepancy exists and cannot be resolved, a report shall be made immediately through the nursing supervisor to the chief of nursing service or respective chief of service (medical officer custodian).

(6) The NAVMED 6710/1 is to be signed in the appropriate space and the reverse side of the DD 1289 is to be dated and signed (see articles 21-42 and 21-43).

(7) Regulations governing the automatic stop order for controlled substances are set forth in article 21-6(3).

21-29. Control by Branches to Pharmacy Service (Regulatory)

(1) Controlled substances shall be requested and delivered to pharmacy branches by the main pharmacy in the same manner that the hospital wards and clinics are supplied. The branch pharmacy shall send a prescription signed by responsible pharmacy personnel for bulk quantities to the main pharmacy. Issue of the schedule II controlled substances, schedule III narcotics, and alcohol, shall be accompanied by NAVMED 6710/1 as described in section III. The local command shall be responsible for delivery methods. In regions where the geographical limitations make the above process impracticable, the branch clinic may order its controlled substances as it does other medical supplies. The same controls

necessary for the regional supply office then pertain. All receipts must be signed for by a commissioned officer.

(2) The monthly unannounced inventory of schedule II controlled substances, schedule III narcotics, and alcohol at branch pharmacies shall be accomplished by an additional member to the Controlled Substances Inventory Board stationed at the facility being inventoried but having no custodial responsibilities. Such inventory shall be called by the senior member of the Board and the results sent to such member, with copies to the branch clinic officer in charge or medical officer/representative, as applicable, and to the chief of pharmacy service.

Note.—There are no articles 21-30 through 21-39.

Section III. FORMS, RECORDS, AND REPORTS

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21-40. General (Regulatory)

(1) Records shall be maintained delineating certain procedures conducted within all Navy medical and dental facilities. Among mandatory requirements for recordkeeping are the prescribing of drugs, handling of controlled medicinals, quality control procedures, and investigational drug handling. Standardized forms are available for all procedures except quality control.

21-41. Prescription Forms (Regulatory)

(1) The DOD Prescription (DD 1289) shall be used, except as provided in article 21-50(10), for all single prescriptions, all controlled drugs, and investigational drug prescriptions.

(2) The Polyprescription (NAVMED 6710/6) may be used when a number of noncontrolled drugs are prescribed for one patient. Restrictions outlined in article 21-5(2) shall apply to use of the polyprescription.

21-42. Controlled Drug Forms (Regulatory)

(1) *Narcotic and Controlled Drug Inventory-24 Hour (NAVMED 6710/4).*—

(a) The NAVMED 6710/4 shall be signed by the ward charge nurse on each watch after the nurse has checked the drugs prior to being relieved. Where feasible and practicable, it is also strongly recommended that the drugs be checked concurrently by the nurse reporting for duty and by the nurse to be relieved. Any discrepancies noted shall be reported immediately to the nursing supervisor. The record is usable for 2 weeks, 1-week period on each side. The night nurse shall initiate the record.

(b) The serial numbers of new NAVMED 6710/1's received from the pharmacy during each watch shall be entered. The serial numbers of completed NAVMED 6710/1's returned to the pharmacy shall be entered and the pharmacist or authorized representative shall acknowledge receipt by initialing in the appropriate column.

(c) At the time specified in local instructions, the nursing supervisor shall audit the ward controlled substances supplies. After the audit, the nursing supervisor shall date and sign the NAVMED 6710/4.

(2) *Narcotic and Controlled Drug Account Record (NAVMED 6710/1).*—

(a) Upon receipt of a properly completed prescription, a separate Narcotic and Controlled Drug Account Record (NAVMED 6710/1) shall be prepared by the pharmacy for each schedule II controlled substance, schedule III narcotic, alcohol, and any drug which, in the opinion of the commanding officer, requires control procedures.

(b) All NAVMED 6710/1's shall be kept in a controlled drug book. (See subart. (3) below.)

(c) All entries shall be made in black ink. Errors shall be corrected by drawing a line through the erroneous entry and having the person making the correction sign the entry. The correct entry shall be recorded on the following line, if necessary.

(d) If a new issue is received before the old issue is completely expended, the new NAVMED 6710/1 shall be inserted in back of the current record. The serial number of the new NAVMED 6710/1 shall be entered in the NAVMED 6710/4.

(e) The heading for each NAVMED 6710/1 shall be completed at the time of issue. The body shall be used for recording expenditures and balances only.

(f) Each time a drug is expended, complete information shall be recorded: date, time, patient, doctor's name, by whom given, amount expended, and balance on hand (NAVMED 6710/1).

(1) All amounts shall be recorded in Arabic numerals. Where the unit of measure is a milliliter (ml) and the amount used is less than a ml, it shall be recorded as a decimal; e.g., 0.5 ml, rather than as a fraction.

(2) When a fraction of the amount is expended to the patient, it shall be placed in parentheses before the amount recorded in the expended column; e.g., an entry of (0.010)l on the morphine sulfate 0.016 gm record indicates that one ml was expended and that 0.010 gm was administered.

(3) If a single dose of a controlled substance is accidentally damaged or contaminated during preparation for administration, or is refused by the patient after preparation, the dose shall be destroyed and a brief statement of the circumstances shall be entered on the NAVMED 6710/1. Circumstances outlined above and in art. 21-42(2)(c) shall be signed as cognizant in the NAVMED 6710/1 by a second nurse.

(4) If multiple doses of a controlled substance are damaged or contaminated, the supervisor shall record the disposition of the drug, including the date, amount of the drug, brief statement of disposition, and the new balance. Both the supervisor and the witnessing nurse shall sign the NAVMED 6710/1.

(5) Deteriorated drugs shall be returned by wards and clinics to the pharmacy where they will be disposed of in accordance with article 21-26.

(g) The completed NAVMED 6710/1, along with the counter-type dispenser, shall be returned to the pharmacy. The pharmacy officer or authorized assistant shall enter on the NAVMED 6710/5 the date the form was returned to the pharmacy. This information shall be entered on the appropriate line bearing the same serial number (prescription number) as the NAVMED 6710/1.

(h) Monthly, the pharmacy shall report to nursing service all NAVMED 6710/1's still outstanding 30 days from date of issue. The report shall be verified by nursing service and returned to the pharmacy for reconciliation. Discrepancies shall be reported to the commanding officer via report of the Controlled Substances Inventory Board.

(3) *Controlled Drug Book.*—

(a) Each ward, clinic, or other activity drawing controlled substances from the pharmacy shall maintain a looseleaf notebook containing the Narcotic and Controlled Drug Inventory—24 Hour (NAVMED 6710/4) in the first section, and individual Narcotic and Controlled Account Records (NAVMED 6710/1) in the latter sections.

(b) The nursing supervisor shall remove all filled NAVMED 6710/4's over 3 months old from the Narcotic and Controlled Drug Book, and transfer them to the hospital archives for disposition in accordance with SECNAVINST 5212.5 series.

(4) *Perpetual Inventory of Narcotics, Alcohol, and Controlled Drugs (NAVMED 6710/5).*—

(a) A separate NAVMED 6710/5 shall be prepared for each schedule II controlled substance, schedule III narcotic, and alcohol. All boxes and columns except as noted below are self-explanatory:

(1) *Name of Drug.*—Enter generic name of drug or proprietary name as appropriate, e.g., "Codeine Sulfate."

(2) *Strength.*—Express as gm, mg.

(3) *Unit.*—Enter table or ampule as appropriate; for liquids or powders, enter ml or gm as appropriate.

(4) *Prescription or Requisition Number.*—Enter appropriate prescription number or requisition (voucher) number. For issues returned to the pharmacy, enter the source.

(5) *Recipient.*—Enter "pharmacy" for receipts. Enter ward number, name of clinic, or name of patient, as appropriate, for expenditures.

(6) *NAVMED 6710/1 Returned.*—The date the NAVMED 6710/1 is returned to the pharmacy shall be entered on the appropriate line bearing the same serial number or prescription number.

(b) On request of the senior member of the Controlled Substances Inventory Board, the chief of the pharmacy service, or authorized assistant, shall total the Quantity Received column and the Quantity Expended column for inspection by the Board.

(c) Upon completion of inspection, one member of the Board shall initial the receipts and expenditures columns.

(d) The foregoing procedures may be modified to record the information and maintain surveillance using the science of computers.

21-43. Quality Control Forms (Regulatory)

(1) Quality control is important for proper conformity and safety of the drug products to be dispensed. The two main areas to benefit from quality control are compounding and prepackaging. A locally prepared form shall be used which will provide clearly definable material sources (manufacturer's names, lot numbers, and expiration dates), procedures used, intermediary and final checks by supervisory personnel, and sample labeling.

21-44. Investigational Drug Forms (Regulatory)

(1) Investigational drugs shall be dispensed by the pharmacy. NAVMED 6710/2, Investigational Drug Data Record, and NAVMED 6710/3, Investigational Drug Inventory and Prescription Record shall be used in accordance with BUMEDINST 6710.49 series.

21-45. Availability of Forms (Regulatory)

(1) DD Form 1289 and NAVMED Forms 6710/1, 6710/4, 6710/5, and 6710/6 are available from cognizance symbol "11" stock points of the Navy supply system.

(2) NAVMED Forms 6710/2 and 6710/3 are available from BUMED.

(3) Supplies of the Report of Theft of Controlled Substances (DEA Form 106) may be obtained from the nearest Regional Drug Enforcement Office or the Drug Enforcement Administration, 1405 "I" St., N.W., Washington, D.C. 20005.

21-46. Publications (Regulatory)

(1) NAVMED P-5095, Poisons, Overdoses, and Antidotes, is available from the Naval Publications and Forms Center, 5801 Tabor Ave., Philadelphia, PA 19120.

(2) The Navy Medical and Dental Material Bulletin is published periodically by the Naval Medical Materiel Support Command for distribution to all ships and stations with medical and dental personnel assigned.

21-47. Report (Regulatory)**(1) *Controlled Drug Inventory Report.*—**

(a) The Controlled Drug Inventory Report shall be prepared monthly, more frequently if necessary, by the pharmacy service after inventory for submission by the Controlled Substances Inventory

Board. This report shall list each item in stock, together with its strength and unit of issue. The report shall show the amount remaining last report, quantity received, quantity expended, and balance on hand.

(b) The Controlled Drug Inventory Report shall be submitted for approval to the commanding officer by the Controlled Substances Inventory Board, stating that the inventory was conducted in accordance with this chapter and existing local instructions. In addition, this report shall state the findings (discrepancies) of the Board and any recommendations.

21-48. Disposition of Records (Regulatory)

(1) All prescriptions and pharmacy records shall be disposed of in accordance with SECNAVINST 5212.5 series.

Section IV. DRUG DISPENSING WITHOUT A PHARMACIST

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21-50. Hospital Corps Personnel on Independent Duty (Regulatory)

(1) Hospital corps personnel are assigned to medical department duties in small vessels, shore stations, Fleet Marine Force, and mobile field units, to which no medical officer is attached and perform all the duties required of the medical department. These duties include medical department administration and, to the extent for which qualified, the professional duties prescribed for medical officers of ships and stations. To make controlled substances available to Hospital Corps personnel assigned to duty independent of a medical officer, fleet, force or type commanders, commanding officers, or other appropriate authority may authorize deviation from the control procedures established in this chapter, but NOT from the general intent concerning receipt, custody, and issue of the items. This deviation in no way relieves a command of the responsibility for controlled material.

(2) Custodial responsibility for controlled substances and alcohol shall be vested in a commissioned officer.

(3) No officer of the Medical Department of the Navy shall take or receive into custody on board ship or in any Navy or Marine Corps establishment any controlled substances except as may be authorized (a) for medicinal purposes, (b) for retention as evidence in disciplinary actions, or (c) by Navy Regulations. Working stocks of these substances may be issued from time to time for dispensing purposes to the officer or enlisted person in charge of the pharmacy. Such person shall be required to keep an accurate record of receipts and expenditures and to keep these substances under lock when not in use. Except as provided above, a custodial officer shall not permit any of these substances to be placed in the possession of any person in quantities other than the amounts required for immediate consumption by patients, or for use in emergency, such as combat. All drugs shall be dispensed under the supervision of Medical Department representatives at activities where there are no officers of the Medical Department.

(4) Officers of the Medical Department are authorized to issue controlled substances, for medicinal purposes only, to commanding officers of ships and to pilots of aircraft to which no Medical Corps officer is attached.

(5) An officer of the Medical Department, or if such officer is unavailable, then an officer designated by the commanding officer, shall keep in a separate compartment, under lock, all unissued controlled substances, alcohol, and substances classified as dangerous, poisonous, or otherwise controlled. Monthly, unannounced inventory of all controlled drugs shall be made by the Controlled Substances Inventory Board and a report made to the commanding officer. The keys shall always be in the custody of an officer. Personnel of the Medical Department shall assure that all such substances under their charge are properly labeled.

(6) The executive officer, or other designated officer, shall arrange for the care and safe custody of all keys and require strict compliance with instructions concerning the receipt, custody, and issue of controlled substances and alcohol contained in the law, U.S. Navy Regulations, and this manual.

(7) Custodians or their designated assistants shall retain the keys to the place of storage while on duty. When relieved, they shall deliver the keys to their relief or to a responsible person designated by local instructions. A copy of the combination of a safe, if used, shall be sealed in an envelope and deposited with the commanding officer or an officer designated by the commanding officer.

(8) An officer of the Medical Department, or if such an officer is not available, the senior Medical Department representative, shall take charge of the medical storeroom and maintain custody of the key. However, the medical officer, if one is assigned, or such other officer or petty officer designated by the commanding officer, shall be responsible for the security of the contents of the medical stores kept therein. Controlled substances and alcohol shall be kept in separate lockers and the keys to these lockers shall always be in the custody of an officer.

(9) Directives issued by fleet, force or type commanders, commanding officers, or other appropriate authority, may authorize the following deviations from the controls established in this chapter:

(a) The senior Hospital Corps member at an activity not having a medical officer may be authorized to deviate from the control procedures established by this chapter, but not the intent regarding receipt, custody, and issue of controlled substances, alcohol, and other dangerous and controlled drugs.

(b) The senior Hospital Corps member may prescribe and administer only those controlled substances listed in the activity's authorized medical allowance list (AMAL) (revision or augmentation of controlled substances in AMAL's of activities without medical or dental officers may be made only by type commanders, medical officers, or their higher authority). DD Form 1289 shall be prepared and filled in accordance with this chapter except that prescriptions not signed by a medical officer, dental officer, podiatrist, or civilian physician employed by the Armed Forces shall be countersigned by the commanding officer or a duly appointed officer representative (see art. 21-5).

(10) Hospital Corps personnel on independent duty are not required to use the DOD Prescription (DD 1289) for prescribing drugs other than con-

trolled drugs, unless directed by the commanding officer or higher authority. This does not relieve independent duty personnel from complying with article 21-5(9).

21-51. Operational or Emergency Situations (Regulatory)

(1) Special instructions should be issued by appropriate authority relative to the receipt, custody, and issue of controlled substances, alcohol, and dangerous and controlled drugs, or first aid kits containing the substances, which, in the best interest of the Navy, may require deviation from the controls established in this chapter due to operational and/or emergency situations.

Chapter 22

PREVENTIVE MEDICINE AND OCCUPATIONAL HEALTH

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Section I. GENERAL

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22-1. Scope

(1) The fields of preventive medicine and occupational health extend into activities, under the cognizance of offices and commands of the Navy Department, where there are conditions which affect the health of the personnel of the Navy. Instructions are issued from time to time by BUMED, commanders in chief, and commanding officers concerning certain provisions of preventive medicine affecting administrative and military functions.

22-2. Responsibility

(1) The medical officer is responsible for establishing health standards and for recommending to the commanding officer the application of such measures

as may be necessary to maintain the health of the command.

22-3. Procedures

(1) The medical officer shall adhere to any procedures promulgated by a superior authority. When no instructions have been issued by proper superior authority, the medical officer shall propose for adoption by the commanding officer such measures as are necessary. Requests for technical advice, surveys, or investigations may be forwarded via appropriate channels to commands having environmental health officers, industrial hygienists, and preventive medicine technicians. Whenever conditions or circumstances arise which are unusual or require special attention, a special report shall be submitted to BUMED and the area environmental and preventive medicine unit.

Section II. ENVIRONMENTAL HEALTH AND INDUSTRIAL HYGIENE

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22-4. Environmental Health

(1) The cognizant medical authority shall be responsible for the following:

(a) Inspection, investigation, recommendation, and supervision of all matters pertaining to sanitation, including the sanitary aspects of food and food handling, water, sewage and waste disposal, housing, and other elements of the environment affecting health, and keeping the commanding officer informed in these matters.

(b) Indoctrination of the personnel of the ship, station, or activity in the latest advances in sanitary science and preventive medicine, including accident prevention and industrial health.

(c) Cooperation with civilian personnel and governmental agencies associated with health problems that may affect naval personnel at or in the vicinity of the command.

(d) Keeping records of inspection and reinspection, investigations, and recommendations.

(e) Preparing local reports.

22-5. Swimming Sites

(1) *Recommendations.*—The medical officer or Medical Department representative shall make appropriate recommendations to the commanding officer concerning the sanitary maintenance to be observed in and around swimming sites, and shall

further recommend that swimming be prohibited in contaminated waters. The Manual of Naval Preventive Medicine, Chapter 4, Swimming Pools and Bathing Places, NAVMED P-5010-4, establishes swimming site standards.

22-6. Industrial Hygiene

(1) The cognizant medical authority shall have the responsibility for planning and conducting an effective industrial health program which shall include the following:

(a) Study the occupational health problems of the ship, station, or activity.

(b) Conduct surveys of potential health hazards in specific activities and processes.

(c) Collect field and laboratory samples pertaining to occupational health exposures.

(d) Make laboratory analysis on samples taken in the field and on any material submitted with reference to causation of occupational disease.

(e) Prepare reports of findings, recommendations, and conclusions evaluating the hazards observed occupational health conditions.

(f) Maintain records and files of studies and examinations.

(2) Industrial hygiene services for operation units for the recognition, evaluation, and control of hazards in the work environment are available by contacting the cognizant preventive medicine unit.

Section III. SANITARY STANDARDS FOR LIVING SPACES

	Article
Barracks	22- 7
Berthing Spaces and Sanitary Facilities Afloat	22- 8
Hospital Nursing Units	22- 9
Confinement Facilities Afloat	22-10

22-7. Barracks

(1) The cognizant medical authority shall make routine inspections of barracks in order to maintain Navy standards of sanitation.

(2) The following are recommended minimum health/habitability criteria per enlisted person in all barracks:

- 72 ft.² (6.48 m²) of floor space per person.
- 500 ft.³ (15 m³) of room space per person.
- 6 ft. (180 cm) minimum distance between heads of sleeping persons.

When situations occur that may require deviation from the above criteria, advice should be requested from the area environmental and preventive medicine unit.

(3) The minimum proportions of plumbing fixtures to the number of personnel to be accommodated are as follows:

- Water closets . . . 1 for every 20 persons
- Urinals 1 fixture for every 25 men
- Lavatories 1 basin or wash sink for every 5 persons
- Showers 1 for every 25 persons

22-8. Berthing Spaces and Sanitary Facilities Afloat

(1) The medical officer or Medical Department representative shall make routine inspections of the

- Floor area per bed 100 ft.² (9 m²).
- Cubic space per bed 1,000 ft.³ (30 m³) to 2,000 ft.³ (60 m³).
- Height of ceiling 8'6" (255 cm) to 10'0" (300 cm).
- Bed spacing 8 ft. (240 cm) center to center.

1 lavatory for each toilet room in a bedroom.

1 lavatory for each 6 patients when private toilet rooms are not provided.

1 water closet for each toilet room in a bedroom.

1 water closet/urinal for each 6 patients when private toilet rooms are not provided for individual bedrooms.

1 shower for each private bedroom.

1 shower for each obstetrical bedroom.

1 shower or tub for each 7 patients for hospitals of 100 beds or more, exclusive of private and obstetrical bedrooms.

1 shower or tub for each 6 patients for hospitals of less than 100 beds, exclusive of private and obstetrical bedrooms.

1 service sink for each nursing unit.

22-10. Confinement Facilities Afloat

(1) *Inspections.*—A member of the medical department shall make a daily determination as to the

sanitary condition of berthing spaces, toilets, lavatories, and bathing facilities. Berthing spaces shall be clean, sufficiently ventilated, and well illuminated. Head-to-foot sleeping arrangements of occupants of adjacent beds are recommended to reduce the potential of air-borne disease transmission. Excellent standards of habitability contribute immeasurably to the health and well-being of the crew.

(2) Water closets, urinals, lavatories, and showers shall at all times be in functional condition. Shower curtains, bulkheads, and decks shall be free of mildew, odor, and soap accumulations. Sewage back-flow through deck drains constitutes an extremely unsanitary condition and shall be reported for immediate correction.

(3) Details of living space sanitation are contained in the Manual of Naval Preventive Medicine, Chapter 2, Sanitation of Living Spaces and Related Service Facilities, NAVMED P-5010-2, and OPNAVINST 9640 series, shipboard habitability program.

22-9. Hospital Nursing Units

(1) For Navy purposes, a nursing unit accommodating 30-40 patients is a size most adequate and economically administered. In tropical climates, and in hospitals caring for a large number of convalescent patients, the number of accommodations in the nursing unit may vary in accordance with environmental conditions.

(2) The following factors are considered basic:

health of the prisoners and the sanitary condition of the confinement facilities.

(2) *Afloat.*—Cell dimensions and sanitary facilities shall conform to standards set forth by the Naval Sea

Systems Command. Ventilation, heating, and illumination standards shall conform to General Specifications for Ships of the U.S. Navy. Detailed information concerning shipboard detention facilities should also be referred to the General Specification for Ships of the U.S. Navy, Naval Sea Systems Command.

(3) *Ashore.*—Sanitary standards stated in the Manual of Naval Preventive Medicine, NAVMED P-5010, shall be complied with. Detailed information concerning building and structural dimensions appear in Design Manual DM-37, Naval Facilities Engineering Command, and pertinent Department of Defense instructions.

Section IV. LIGHTING, HEATING, AND VENTILATION

	Article
Lighting, Heating, and Ventilation	22-12

22-12. Lighting, Heating, and Ventilation

(1) The medical officer or Medical Department representative shall make recommendations to the commanding officer for proper lighting, heating, and ventilation of ships and barracks.

(2) Lighting intensities are prescribed by the OPNAVINST 9460 series, the Naval Sea Systems Command, and the Naval Facilities Engineering Command. Reference should be made to the appropriate manuals of the Naval Sea Systems Command, the

Naval Facilities Engineering Command, and OPNAVINST 9640 series.

(3) The purpose of heating and ventilating living spaces afloat and ashore is to provide a comfortable and safe atmosphere for the occupants. Ventilation ducts and vents are to be maintained free of dust, grime, and grease accumulations to ensure efficient and safe operation. Reference should be made to the appropriate manuals of the Naval Sea Systems Command, the Naval Facilities Engineering Command, and OPNAVINST 9640 series.

Section V. FOOD AND WATER SUPPLY

	Article
Food	22-13
Water	22-14

22-13. Food

(1) The medical officer or Medical Department representative is charged with the following responsibilities:

(a) Make frequent inspections of the sanitary aspects of food storage, preparation, and service; examine menus to ascertain that a well-balanced diet is provided giving consideration to requirements specified in BUMED Instruction 10110.3 series; and make appropriate recommendations to the commanding officer.

(b) Ensure the continued maintenance of the standards of food sanitation as set forth in the Manual of Naval Preventive Medicine, Chapter 1, Food Sanitation, NAVMED P-5010-1.

(c) Ensure that all foods are prepared in clean surroundings by personnel free of communicable diseases and open lesions of the hands, face, and neck.

(d) Ensure that foods of a proteinaceous nature are not permitted to remain at room temperature for a period exceeding 3 hours, and are refrigerated at a temperature not exceeding 40° F (4° C).

(e) The Medical Department representative shall certify the acceptability of food and potable water in the event of nuclear, biological, or chemical (NBC) warfare. The Medical Department representative shall consult the Naval Supply Systems Com-

mand Manual (Subsistence chapter) for guidance in matters of recovery after NBC attack.

22-14. Water

(1) The Medical Department is charged with the responsibility for advising and making recommendations to ensure a safe supply of potable water. The Medical Department representative shall make special surveys of water supply systems, including all measures for purification, and make necessary recommendations for the correction of sanitary defects. In the event of an acute shortage of water, the commanding officer shall be advised relative to the rationing of water.

(2) In determining the potability of water, the Medical Department representative will be guided by appropriate instructions and the Manual of Naval Preventive Medicine, (Chapter 5, Water Supply Ashore, NAVMED P-5010-5, and Chapter 6, Water Supply Afloat, NAVMED P-5010-6).

(3) For purification of water in the field, reference should be made to field technical manuals and the Manual of Naval Preventive Medicine.

(4) Reference should be made to the Naval Sea Systems Command Manual for the proper operation of water supply plants aboard ships and to the Naval Facilities Engineering Command manuals and NAV FACINST 11330.14 series for drinking water at Navy shore activities.

Section VI. GARBAGE, REFUSE, AND SEWAGE DISPOSAL

	Article
Garbage and Refuse Disposal	22-15
Sewage Disposal	22-16

22-15. Garbage and Refuse Disposal

(1) The medical officer, or Medical Department representative, shall make the necessary inspections to ensure proper methods and adequate frequency of garbage and refuse disposal. Aboard ship, garbage and refuse may be dumped at sea, at the discretion of the commanding officer. Shipboard garbage grinders are not to be operated in harbor and river areas or within 12 nautical miles of the U.S. coast. Ashore, garbage and refuse may be disposed of in a manner prescribed by the Naval Facilities Engineering Command Manual, Refuse Disposal (MO-213), and the Manual of Naval Preventive Medicine, Chapter 8, Garbage and Refuse Disposal, NAVMED P-5010-8.

22-16. Sewage Disposal

(1) The medical officer, or Medical Department representative, shall make necessary inspections and recommendations to the commanding officer for the sanitary disposal of sewage and liquid industrial wastes. Navy policy on environmental pollution control is stated in OPNAVINST 6240.3 series. Reference shall be made to NAVMED P-5010-7, Manual of Naval Preventive Medicine, Chapter 7, Wastewater Treatment and Disposal Ashore and Afloat; Naval Facilities Engineering Command publications; Sewage and Industrial Waste Systems (NAV DOCKS MO-212); and Ship-to-Shore Hose Handling Operations Manual (NAVFAC MO-340).

Chapter 23

REPORTS, FORMS, AND RECORDS

Sections

	Articles
I. Command Reporting Requirements	23- 1 through 23- 2
II. NAVMED, Standard Federal, Department of Defense, and Other Forms ...	23-50 through 23-63
III. Release of Information From Records	23-70 through 23-79

Section I. COMMAND REPORTING REQUIREMENTS

	Article
General	23-1
Tabulation of Command Reporting Requirements	23-2

23-1. General

(1) Medical Department personnel are required to prepare and submit certain special and periodic reports as specified in article 23-2. Reference to official instructions for the preparation and submission of each of these reports will be found in the tabulation. Additional reports may be required of representatives of the Medical Department by U.S. Navy Regulations or other competent authority.

(2) For purposes of identification and control, each report required by COMNAVMECOM has been assigned a report symbol from the Department of the Navy Standard Subject Identification Codes, SECNAVINST 5210.11 series.

(3) No report will be considered as an official continuing reporting requirement of COMNAVMECOM unless it bears a report symbol. The report symbol where practicable will be placed on all reports (letter and form) sent to COMNAVMECOM. In addition, all correspondence referring to an official reporting requirement of COMNAVMECOM should cite the title and symbol of the report.

(4) Subarticle 23-50(5) contains data on availability and stock levels of reporting forms.

(5) The original copy only of each report will be sent to COMNAVMECOM unless otherwise indicated. Where practicable, signatures, as required, should appear on the reports, obviating the need for letters of transmittal.

23-2. Tabulation of Command Reporting Requirements

Symbol	Title	Format	Frequency ¹	Requiring directive	NMC RCS Sponsor	Preparing activities
1050-1	Annual Leave and Temporary Additional Duty for Commanders and Commanding Officers.	Message	S	NMCINST 1050.1 series.	09	NMC command activities.
1306-1	Sixty-Day Medical Hold Report.	. . .do	S	BUPERSINST 1306.72 series.	31	Hospitals & med. clinics.
1306-2	Medical Holding Company Transmittal Record.	Letter.	M	. . . do	31	Do.
1500-1	Report of Integral parts of training	Letter.	A	NMCINST 1500.7 series.	54	NMC command activities.
3900-3	Complication in Study Using Human Subjects.	Message or speed-letter.	S	BUMEDINST 3900.6 series.	02D	NMC command activities conducting research on human subjects.
4000-1	Request for Potency Extension of Dated Material.	Letter.	S	BUMEDINST 6710.62 series.	42	NMC command activities.
4010-4	Recovery and Utilization of Precious Metals.	Format.	Q	NMCINST 4010.1 series.	42	Do.
4100-2	Annual Energy Assessment Report.	. . .do	A	NMCINST 4100.1 series.	43	Do.
4500-1	Report of Excess Personal Property.	SF 120.	S	NMCINST 4500.1 series.	42	Ships & stations having medical dept. personnel.
4550-1	Semiannual Master Investment Equipment Inventory.	Letter.	SA	BUMEDINST 4235.5 series.	42	NMC command activities.
4550-3	Investment Equipment Acquisition Status Report.	. . .do	M	. . .do	421	Do.
4730-2	Assignment of Medical/Dental Inspectors to INSURV	. . .do	S	NMCINST 4730.1 series.	22	Do.
4812-1	Logistic Support and Mobilization Plan (LSMP).	. . .do	A	NMCINST S4812.1 series.	41	NMC command activities.
5353-4	Activity Profile Report.	NAVMED 5353/1 . . .	Q	NMCINST 5353.1 series.	342	Hospitals and regions.
5355-6	Report of Excused Positive Urinalysis.	Letter.	S	NMCINST 5355.1 series.	34	NMC command activities.

5360-1	Report of Burial in Navy Cemeteries or Plots.	Letter.	S	NMCINST 5360.1 series.	33	Activities responsible for maintenance of naval plots and cemeteries.
5360-3	Report of Dispositions and Expenditures-Remains of Dead.	. . .do	S	. . .do	33	Activities having care of the dead contracts.
5360-4	Unidentified or Group Remains.	Message	S	. . .do	33	Activities responsible for recovery operations and identification processing of remains.
5360-5	Subsequent Recovery of Partial Remains.	. . .do	S	. . .do	33	Do.
5360-6	Search, Recovery, and Identification Operations Progress.	. . .do	S	. . .do	33	Do.
5360-10	Interment Allowance Review Data.	Letter.	A	NMCINST 5360.1 series.	33	Medical officers receiving requests for payment of funeral/interment allowances.
5360-11	Decedent Affairs Death Report.	Message	S	NMCINST 5360.1 series.	33	Ships and stations as required by instruction.
5360-13	Disaster Involving Other Service Dead.	Message	S	. . .do	33	Do.
5360-14	Escort of Deceased Naval Personnel.	Letter.	S	. . .do	33	Activities providing transportation for remains or the escort's organization.
6000-3	Clinical Investigation Study Proposal and Budget Estimate.	. . .do	S	NMCINST 6000.4 series.	54	NMC command activities that wish to conduct clinical investigations.
6000-6	Clinical Investigation-Resources Summary Estimate.	. . .do	A	. . .do	54	Hospitals with regional clinical investigation centers.
6000-10	JCAH Survey Recommendations Implementation Status Report	NAVMED 6000/1 . . .	S	BUMEDINST 6000.2 series.	35	Hospitals and clinics undergoing JCAH survey.

See footnote at end of table.

23-2. Tabulation of Command Reporting Requirements-Continued

Symbol	Title	Format	Frequency ¹	Requiring directive	NMC RCS Sponsor	Preparing activities
6010-23	Annual Regional Quality Assurance Assessment Summary.	NMCINST 6320.7 Appendix D.	A	NMCINST 6320.7 series.	35	Geographic naval medical commands.
6220-3	Disease Alert Report.	Message, speedletter, or letter.	S	NMCINST 6220.2 series.	24	Ships and stations having medical personnel.
6260-1	Report of Occupational Health Services.	NAVMED 6260/1 . . .	A	BUMEDINST 6260.7 series.	24	Medical activities providing care to civilian employees.
6300-1	Medical Services and Outpatient Morbidity Report.	NAVMED 6300/1 . . .	M	BUMEDINST 6300.2 series.	01C	Ships and stations having medical personnel.
6300-2	Inpatient Admission/Disposition Record.	NAVMED 6300/5 . . .	D	BUMEDINST 6300.3 series.	01C	Ships and stations providing inpatient care.
6320-7	Health Care Staffing Report.	NAVMED 6320/7 . . .	Q	BUMEDINST 6320.16 series.	01C	Hospitals and medical clinics.
6320-19	Medical Capabilities Report.	Format.	SA	NMCINST 6320.4 series.	33	Hospitals.
6320-29	Credentials Action Report Quarterly Review/Situational Advisor.	NAVMED 6320/28. . .	S	NMCINST 6320.8 series.	35	All naval activities with medical personnel.
6320-34	Message Report--Medical Capabilities.	Message	S/A	NMCINST 6320.4 series.	33	Hospitals.
6320-40	Inpatient Occurrence Screening Report.	Letter.	S/A	NMCNOTE 6320 series.	35	Hospitals.
6320-42	DEERS Project Officer Report	Message	S	NMCINST 6320.3A series.	33	All Medical commands w/DEERS capability.
6320-46	Sameday Surgical Procedure Report.	Letter.	S	NMCINST 6320.21 series.	311	Hospitals/med/den clinics.
6410-3	Aerospace Physiology Training Report.	NAVMED 6410/3 . . .	Q	MANMED art. 14-16.	23	Aviation activities utilizing aerospace physiology training devices for training purposes.

6440-1	MMART Readiness Report.	Letter.	Q	NMCINST 6440.2 series.	41	NMC command activities sponsoring MMART units and supply blocks.
6440-1A	MMART Monthly Progress Report.	. . .do	M	. . .do	41	All commands supporting MMART units.
6440-2	Assumption of Alert Status Report.	Message	S	. . .do	41	Do.
6440-3	Post Deployment Critique.	Letter.	S	. . .do	41	Do.
6440-6	Unit Augmentation Readiness Report.	Format.	Q	NMCINST 6440.3 series.	41	CONUS GEOCOMS
6470-1	Personnel Exposure to Ionizing Radiation.	NAVMED 6470/1 . . .	A/S	NAVMED P-5055, Radiation Health Protection Manual.	21	Ships or stations having personnel occupationally exposed to sources of ionizing radiation and not having data processing equipment.
6470-2	Personnel Exceeding Radiation Exposure Limits.	NAVMED 6470/1 and/or message.	S	. . .do	21	Ships or stations having personnel occupationally exposed to sources of ionizing radiation.
6470-3	Personnel Exposure to Ionizing Radiation (EDP).	Punch cards	A/S	. . .do	21	Ships or stations having personnel occupationally exposed to sources of ionizing radiation and having data processing equipment.
6470-10	Ionizing Radiation Equipment Survey.	NAVMED 6470/5 thru 6470/9.	S	NMCINST 6470.6 series.	2122	Ships & stations having ionizing radiation devices.
6530-4	Blood Bank Operations Report.	NAVMED 6530/1 . . .	Q	MANMED arts. 14-10 and 14-11 and NMCINST 6530.2 series.	413	Activities having blood banks.
6600-6	DIRS Treatment Report.	NAVMED 6600/8 . . .	M	NMCINST 6600.1 series.	63	Ships and Stations having personnel.
6700-5	Medical/Dental Local Purchases.	NAVMED 6700/2 or NAVMED 6700/5	M	BUMEDINST 6700.20 series.	42	NMC activities procuring medical/dental material locally.

See footnote at end of table.

23-2. Tabulation of Command Reporting Requirements-Continued

Symbol	Title	Format	Frequency ¹	Requiring directive	NMC RCS Sponsor	Preparing activities
6700-6	Medical Casualty Evacuation Material Excesses/Deficiencies.	Letter.	Q	NMCINST 6700.5 series.	42	Activities utilizing the medical air evacuation system.
6700-16	Reporting and Processing Medical Materiel Complaints.	DD 1899	S	BUMEDINST 6710.63 series.	42	Ships and stations having medical/dental material onhand.
6700-21	Report of Assembly of a Diagnostic X-ray System.	FD 2579	S	BUMEDINST 6700.36 series.	42	Ships and stations having diagnostic X-ray systems.
6700-23	Test and Evaluation Summary Format	Letter.	S	NMCINST 6700.1 series.	42	NMC activities.
6700-24	Report of Audiometric Equipment Calibration.	Letter.	A	BUMED 6700. 36 series.	42	Ships & stations having audiometric equipment.
6710-2	Investigational Drug Status Record.	Letter or message .	S	NMCINST 6710.4 series.	00/ NIDRB	Activities having medical/dental personnel.
6710-4	Issues of Controlled Drug Substances.	ADP print out . . .	M	BUMEDINST 6710.58 series.	42	AFS and AS type ships.
6710-10	Investigations Drug Status Record.	NAVMED 6710/9 . . .	S	NMCINST 6710.4 series.	00/ NIDRB	All activities having medical personnel.
6710-11	Narcotic and Controlled Drug Account Record.	NAVMED 6710/1 . . .	W	. . .do.	00/ NIDRB	All activities with medical personnel.
6710-18	Request for Emergency Use of Investigational Drug, Devices, Biologics.	NAVMED 6710/8 . . .	S	NMCINST 6710.4 series.	00/ NIDRB	Stations having Medical Department personnel.
6750-1	Dental Service Report-Equipment and Facilities Supplement.	NAVMED 6750/4 . . .	A	NMCINST 6750.1 series.	06	Ships and stations having dental equipment/facilities.
7302-2	Professional Update Training Funds Obligated.	Message	M	BUMEDINST 4651.1 series.	54	NMC command activities.
7330-11	Analysis of Funded Reimbursables	Letter.	M	NAVMED P-5020.	13	Do.

8 Dec 87	7510-1	Internal Review Status Report. .	Letter.	SA	NMCINST 7510.1 series.	09IR	All echelon 3 commands under COMNAVMEDCOM.
	7510-2	External Audit Visit.	. . .do	S	. . .do.	09IR	Do.
	7510-4	Implementation Status Reporting.	OPNAV 5040/1. . . .	S	. . .do.	09IR	Do.
	10110-2	Food Service Performance Analysis.	NAVMED 10110/2. . .	M	BUMEDINST 10110.2 series.	312	Hospital and medical clinics.
	12595-1	Documentation of Recruitment and Retention Problems.	Format.	S	NMCINST 12595.1 series.	52	Ships & stations having medical personnel.
	12595-2	Civilian Physician's Comparability Allowance Program.	Letter.	A	. . .do.	52	Do.
	12713-2	EEO Counselor's Report of Background Information.	. . .do	S	NMCINST 12713.1 series.	00D1	NMC command activities.
	12713-3	Report of Class Action Discrimination Complaint.	. . .do	S	. . .do.	00D1	Do.
	12713-4	Certified Course Managers and Trainees.	. . .do	S	NMCINST 12713.2 series.	00D1	Do.

¹ Frequency: "D" Daily, "W" Weekly, "M" Monthly, "Q" Quarterly, "SA" Semiannually, "A" Annually, "S" Situational, "A/S" Annual/Situational.

Section II. NAVMED, STANDARD FEDERAL, DEPARTMENT OF DEFENSE, AND OTHER FORMS

	Article
General	23-50
NAVMED 6320/18, Binnacle List	23-51
NAVMED 6320/19, Morning Report of Sick and Injured	23-52
DD Form 877, Request for Medical/Dental Records or Information	23-54
Tabulation of Medical Department Forms	23-60
Tabulation of Standard Federal Forms	23-61
Tabulation of Department of Defense Forms	23-62
Tabulation of Other Prescribed Forms	23-63

23-50. General

(1) COMNAVMECOM has promulgated certain forms which are designed to facilitate reporting, recordkeeping, and administrative efficiency throughout the Medical Department. These forms are tabulated in article 23-60.

(2) For the purpose of identification and control, all Medical Department forms have been assigned a number. All correspondence referring to a form should cite its correct number and title.

(3) COMNAVMECOM also maintains administrative control over the use of certain Standard Federal forms in the Medical Department. These forms are promulgated by the General Services Administration and Interagency Committee on Medical Records to facilitate the exchange of medical information throughout the Federal Government. These forms are tabulated in article 23-61. Department of Defense forms used by the Medical Department are listed in 23-62. Other forms used by the Medical Department and not listed in the preceding articles are listed in 23-63.

(4) The functions of the forms are outlined in the tabulations or in the references cited therein.

(5) Forms available for issue through the Forms and Publications Segment of the Navy Supply System should be ordered when needed from the appropriate forms and publications cognizant "II" supply distribution points in accordance with NAVSUP Publication 2002, Navy Stock List Forms & Publications, Cognizance Symbol I.

(6) Article 23-60 indicates by asterisk those forms which are stocked in the Naval Medical Command. They should be requested directly from COMNAVMECOM.

(7) Stations should maintain a 3 months' and ships a 6 months' supply of forms on hand.

23-51. NAVMED 6320/18, Binnacle List

(1) NAVMED 6320/18 shall be used to excuse an individual from duty for a period of 24 hours or less. It shall be prepared by the senior officer/senior representative of the Medical Department and be submitted to the commanding officer by 0930 daily. The list must be approved by the commanding officer and no names may be added without the commanding officer's permission. After the commanding officer has signed the Binnacle List, it shall be returned to the Medical Department. No quarters patient days may be counted for individuals on the Binnacle List.

23-52. NAVMED 6320/19, Morning Report of Sick and Injured

(1) NAVMED 6320/19 shall be used to excuse an individual from duty for a period of more than 24 hours. It shall be prepared by the senior officer/senior representative of the Medical Department and be submitted to the commanding officer by 1000 daily. It shall contain a list of all sick and injured

personnel excused from duty at that point in time. One quarters patient day shall be counted for each day an individual is included on the Morning Report.

(2) When it is considered necessary to excuse individuals from duty after the Morning Report of Sick and Injured has been submitted, their names shall be added to the Binnacle List and the appropriate report shall be submitted to the commanding officer for approval. If the individuals are still unfit for duty when the next Morning Report of Sick and Injured is submitted, their names shall be added thereto as of the date on which the individual's name was first entered on the Binnacle List and the appropriate number of quarters patient days counted.

(3) If individuals, excused from duty on the Binnacle List, are not ready to return to duty after 24 hours, they shall be included on the next Morning Report of Sick and Injured as of the date they were excused from duty on the Binnacle List and the appropriate number of quarters patient days counted.

(4) An "x" shall be placed in the appropriate block to indicate whether the patient is excused from duty due to illness or injury. Suspected malingering shall be reported to the commanding officer.

Note.—There is no article 23-53.

23-54. DD Form 877, Request for Medical/ Dental Records or Information

(1) Use.—DD Form 877 shall be used to request medical or dental records, whenever

feasible. However, when ordering Health and Dental Records from the National Personnel Records Center, St. Louis, MO, use DD Form 877; no other form will be accepted. The form should be prepared in triplicate.

(2) Action by Requesting Activity.—Enter date and complete items 1 through 10 (except 8b) and item 19.

(a) Check appropriate box(es) in item 8a, RECORDS REQUESTED, to indicate whether military records, Veterans Administration records, or both are required.

(b) Enter in item 9, REMARKS, any other information deemed appropriate to identify the records. Forward original and one copy of DD 877; retain third copy.

(3) Action by Addressee Upon Receipt of DD 877.—

(a) If the requested records are available check the appropriate box(es) in item 8b, RECORDS FORWARDED, complete items 11 through 14 and forward the requested records to the address in item 19, together with the original of the DD 877.

(b) If the requested records are not on hand but their location is known, forward both copies of the DD Form 877 to the present custodian of the records, using items 11 through 14 to request compliance with the basic request.

(c) If the requested records are not on hand and their present location is not known, complete items 11 through 14, or 15 through 18, as appropriate, and return both copies of the DD 877 to the originating activity indicated in item 19.

23-60. Tabulation of Medical Department Forms

NAVMED	Title	Function	Using Activities
1140/1* .	Navy's Active Duty Delay Program for Specialists (Berry Plan, NADDS).	To give required information on status of deferments of doctors in Berry Plan/NADDS program.	NMC and affected activities having medical officers.
1301/1* .	Questionnaire for Fully Trained Specialists.	To obtain information on doctors in the Berry Plan/NADDS program for placement purposes.	Do.
1301/2* .	Reserve Medical Corps Survey.	To provide a file of persons with medical specialties for assigning Medical Corps personnel.	COMNAVMEDCOM.
1301/3* .	Questionnaire for Partially Trained Medical Officers.	. . . .do	NMC and affected activities having medical officers.
1500/2# .	Certificate of Instruction (Nursing).	Certificate for presentation to Nurse Corps officers attending NMC sponsored courses of instruction at Medical Department activities.	NMC and affected activities having Nurse Corps officers.
1500/3* .	Certificate of Accomplishment.	See BUMEDINST 4950.2 series	NMC command activities.
1510/1* .	Certificate of Special Instruction.	Issued to Hospital Corps personnel on completion of a class C medical technical course of instruction.	Medical Department activities conducting class C courses for Hospital Corps personnel.
1510/1A* .	Certificate of Special Instruction.	See BUMEDINST 4950.2 series	NMC command activities.

* Stocked in COMNAVMEDCOM.

Stocked in Health Sciences Education and Training Command, Bethesda, MD.

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CHAPTER 23. REPORTS, FORMS, AND RECORDS

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23-60. Tabulation of Medical Department Forms-Continued

NAV MED	Title	Function	Using Activities
1510/2*	Certificate of Graduation-Basic Corps School.	Issued to personnel on completion of a Basic Hospital Corps School.	Basic Hospital Corps Schools.
1510/3*	Certificate of Instruction-Dental Technician School United States Navy.	Issued to graduates of class A, B, and C dental technician schools upon completion of the prescribed courses of instruction.	Dental activities conducting approved courses of instruction in a class A, B, or C dental technician school.
1510/4*	Certificate of On-The-Job Training.	Issued to Hospital Corps personnel on completion of specialized on-the-job training.	Medical Department activities designated by COMNAVMEDCOM to conduct such training.
1510/6#	Training Evaluation, Supervisor Questionnaire.	To gather feedback on effectiveness of enlisted Medical Department training in formal schools.	Activities with recent graduates from selected HM and DT "C" schools.
1510/7#	Training Evaluation, Graduate Questionnaire.	. . . .do	Do.
1520/1*	Medical Officer Service Training Agreement.	To notify residents of selection for a residency training appointment.	NMC command activities.
1520/3*	Certificate of Internship	Certificate of completion of dental intern training.	NMC and activities approved for dental intern training.
1520/8*	Certificate of Residency.	Certificate of completion of dental residency.	NMC and activities approved for dental residency training.
1520/9*	Certificate of Internship-Clinical Psychology.	Certificate of completion of internship in clinical psychology.	NMC NCR Bethesda only.
1520/10#.	Certificate of Graduate Medical Education.	Certificate of Graduate Medical Education received by Navy Medical Corps officers.	NMC provides to activities approved for graduate medical education training.

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1520/11# .	Graduate Medical Education Application.	Format for completion of application for graduate medical education. (See latest issuance of NMCNOTE 1520 (Medical).)	Ships and stations having Medical Corps personnel.
1520/12# .	Certificate of Fellowship Training.	To provide an official document of graduate medical education for graduates of Navy programs.	Naval Health Sciences Education and Training Command.
1520/13# .	Certificate of Internship Training.	. . . .do	Do.
1520/14# .	Certificate of Residency Training.	. . . .do	Do.
1520/15 .	Certificate of Fellowship.	To acknowledge completion of post-doctoral fellowship at naval dental activities.	Naval dental activities.
1520/16 .	Advanced Dental Education Application.	See latest issuance of NMCNOTE 1520 (Dental).	Ships and stations having dental personnel.
1521/1* .	Certificate of Fellowship.	Issued to dental officers completing fellowships.	NMC and affected activities having dental officers.
1521/2* .	Questionnaire for First Year Graduate Medical Education (GME).	Provides NMC with required information pertaining to graduate medical education.	NMC and activities approved for graduate medical education training.
1521/3* .	First Year Graduate Medical Education Application.	Used by medical students to apply for first year Graduate Medical Education.	NMC.
1532/1* .	Navy and Marine Corps Selection Test Data Answer Sheets.	See BUMEDINST 1532.1 series	Activities designated in the instruction to administer the aviation selection test and designated Coast Guard activities.
1532/1A* .	Academic Qualification Test Scoring Key (AQT Form 1).	. . . .do	Do.

* Stocked in COMNAVMECOM.

Stocked in Health Sciences Education and Training Command, Bethesda, MD.

23-60. Tabulation of Medical Department Forms-Continued

NAVMED	Title	Function	Using Activities
1532/1B*.	Academic Qualification Test Scoring Key (AQT Form 2).	See BUMEDINST 1532.1 series	Activities designated in the instruction to administer the aviation selection test and designated Coast Guard activities.
1532/1C*.	Mechanical Comprehension-Spatial Apperception Scoring Key (MCT Form 1).	. . . .do	Do.
1532/1D*.	Mechanical Comprehension-Spatial Apperception Scoring Key (MCT Form 2).	. . . .do	Do.
1532/1E*.	Mechanical Comprehension-Spatial Apperception Scoring Key (SAT Form 1).	. . . .do	Do.
1532/1F*.	Mechanical Comprehension-Spatial Apperception Scoring Key (SAT Form 2).	. . . .do	Do.
1532/1G*.	Biographical Inventory Scoring Key (BI Form 1 Positive and Negative).	. . . .do	Do.
1532/1H*.	Biographical Inventory Scoring Key (BI Form 2 Positive and Negative).do	Do.
1532/2A*.	Academic Qualification Test (AQT Form 1).do	Do.

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1532/2B*.	Academic Qualification Test (AQT Form 2).do	Do.
1532/2C*.	Mechanical Comprehension Test (MCT Form 1).do	Do.
1532/2D*.	Mechanical Comprehension Test (MCT Form 2).	. . . .do	Do.
1532/2E*.	Spatial Apperception Test (SAT Form 1).	. . . .do	Do.
1532/2F*.	Spatial Apperception Test (SAT Form 2).	. . . .do	Do.
1532/2G*.	Biographical Inventory (B1 Form 1).	. . . .do	Do.
1532/2H*.	Biographical Inventory (B1 Form 2).	. . . .do	Do.
1610/1. .	Off-Duty Remunerative Professional Civilian Employment Request.	See art. 1-22	Activities having Medical Department officers.
4061/1. .	Food Sanitation Training Certificate.	Ready identification of food service workers trained in accordance with SECNAV instructions.	Activities having medical personnel.
4100/1. .	Annual Energy Assessment.	To provide background information on large changes in area or consumption from the previous year.	NMC.
4235/1* .	Medical/Dental Investment Equipment Budget Item Justification Worksheet.	To obtain data base and justification required for programming of shipboard medical and dental investment equipment.	All ships.

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23-60. Tabulation of Medical Department Forms-Continued

NAVMED	Title	Function	Using Activities
4235/2. .	OPN Equipment Budget Item Justification Worksheet.	To provide documentation for investment equipment.	NMC command activities.
5040/1* .	Briefing Data-Personnel.	Provides COMNAVMECOM with personnel data in a standard format in connection with the Command Inspection Program.	NMC command activities.
5040/2* .	Briefing Data-Patient Workload . .	Provides COMNAVMECOM with workload data in a standard format in connection with the Command Inspection Program.	Do.
5230/2* .	Data Processing Service Request. .	To request EAM/EDP services from COMNAVMECOM activities with EAM/EDP equipment.	Activities requesting EAM/EDP support from NMC activities.
5353/1. .	Activity Profile Report.	See NMCINST 5353.1 series	NMC command activities.
5353/2. .	Treatment Effectiveness Assessment	See NMCINST 5353.2 series.	Do.
6000/1* .	JCAH Survey Recommendations Implementation Status Report.	See BUMEDINST 6000.2 series	Hospitals and medical clinics surveyed by the JCAH.
6010/1. .	Collection Agent Ledger.	See NAVMED P-5020, Resource Management Handbook.	Hospitals and medical clinics.
6010/5. .	Staff Locator.	To provide a ready location reference to staff personnel-military and civilian.	Do.
6010/6. .	Collection Agents Receipt.	See NAVMED P-5020, Resource Management Handbook.	Do.
6010/7. .	Cash Service Journaldo	Do.

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6010/8 .	Patient's Valuables.	See NMCINST 6010.1 series.	Activities providing inpatient care.
6010/9 .	Baggage Record Card.	For control of baggage in baggage room. See NMCINST 6010.1 series.	Do.
6010/10 .	Statement of Charges	See NAVMED P-5020, Resource Management Handbook.	Hospitals and medical clinics.
6010/11 .	Operations Scheduled	Local schedule of operations to be performed.	Do.
6010/12 .	Medical Appointments-Daily	To schedule outpatient appointments.	Activities providing outpatient care.
6010/14 .	Incident Reporting Data Sheet . . .	To systematically tabulate incidents by categories per service.	Hospitals and medical clinics.
6010/15 .	Patient Satisfaction Survey	To gather evaluation information from patients admitted to medical clinics and hospitals.	Do.
6010/16 .	Patient Satisfaction Survey, Outpatient.	To gather evaluation from patients seen in the outpatient areas.	Do.
6010/20 .	Annual Regional Quality Assurance Assessment Report.	See NMCINST 6320.7 series.	Do.
6100/1 .	Medical Board Report Cover Sheet.	See arts. 18-23 thru 18-26 and 18-28 thru 18-32 and BUMEDINST 1910.2 and NMCINST 6100.1 series.	Activities authorized to convene a medical board.
6100/2 .	Medical Board Statement of Patient.	See arts. 18-22 and 18-26 and BUMEDINST 1910.2 series.	Do.
6100/3 .	Medical Board Certificate Relative to a PEB Hearing.	See arts. 18-12 and 18-26 and BUMEDINST 1910.2 series.	Do.

*Stocked in COMNAVMEDCOM.

23-60. Tabulation of Medical Department Forms-Continued

NAVMED	Title	Function	Using Activities
6120/1 . .	Competence for Duty Examination . .	See BUMEDINST 6120.20 series.	Ships and stations having medical personnel.
6120/2 . .	Officer Physical Examination Questionnaire.	See art. 15-52.	Medical activities providing physical examinations.
6120/3 . .	Annual Certificate of Physical Condition.	See arts. 15-54 and 15-84	Students enrolled in NROTC and NESEP programs.
6150/2 . .	Special Duty Medical Abstract . . .	See arts. 16-58 thru 60	Activities having a medical officer.
6150/4 . .	Abstract of Service and Medical History.	See arts. 16-55 thru 57	Ships and stations having medical personnel.
6150/5 . .	Medical Warning Tag Order	See NMCINST 6150.2 series	Ships and stations having a medical/dental officer.
6150/7 . .	Health Record Receipt, File Charge-out, and Disposition Record.	See arts. 16-4A(1)(c)(6) and 16-18(4).	Ships and stations having medical personnel.
6150/10-19	Treatment Record.	Serves as jacket to house health care treatment records. (See NMCINST 6150.1 series.)	Hospitals and medical clinics.
6150/20. .	Problem Summary List.	See NMCINST 6150.3 series.	Do.
6224/1 . .	Tuberculosis Contact/Converter Follow-up.	See BUMEDINST 6224.1 series	Ships and stations having medical personnel.

6230/3 . .	Informed Consent Form	To advise patients of the benefits and risks of influenza immunizations and to obtain their consent.	Activities providing immunizations during the annual influenza immunization program.
6240/1. .	Food Service Sanitation Inspection.	See NAVMED P-5010, Manual of Naval Preventive Medicine.	Activities having medical personnel.
6250/1* .	Shipboard Pest Control Technology Certificate.	See BUMEDINST 6250.13 series.	NAVENPVNTMEDU and NAVDISVECT ECOLCONCEN.
6260/1* .	Report of Occupational Health Services.	See BUMEDINST 6260.7 series	Medical activities providing care to civilian personnel.
6260/2. .	Hazardous Noise Warning Decal. . .	See OPNAVINST 6260.2 series	Ships and stations having hazardous noise environments or devices.
6260/2A .	Hazardous Noise Labels. . . . .	. . . .do	Do.
6260/3 .	Industrial Hygiene Workload Summary.	See NMCINST 6260.1 series	All activities with medical personnel including ships.
6260/4 .	Industrial Hygiene Services Backlog Summary.	. . . .do	Do.
6260/5 .	Periodic Health Evaluation, Navy Asbestos Medical Surveillance Program.	See OPNAVINST 5100.23 series and NMCNOTE 6260 (latest issuance).	Hospitals and medical clinics.
6300/1. .	Medical Services and Outpatient Morbidity Report.	See BUMEDINST 6300.2 series	Ships and stations providing outpatient care.
6300/5. .	Inpatient Admission/Disposition Record.	See BUMEDINST 6300.3 and NMCINST 6320.11 series.	Ships and stations providing inpatient care.
6300/6. .	Inpatient Data Change Record.do	Activities providing inpatient care.

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23-60. Tabulation of Medical Department Forms-Continued

NAVMED	Title	Function	Using Activities
6300/7*	Inpatient Data Correction Record. .	See BUMEDINST 6300.3 and NMCINST 6320.11 series.	Activities providing inpatient care.
6300/8*	Inpatient Data Transmittal Recorddo . . . . .	. . . . .do	Do.
6300/11 .	Medical Facility Incident Report. .	To provide a standardized form for documenting incidents.	Hospitals and medical clinics.
6300/12 .	Abortions and Related Services. . .	To provide guidance in reporting data on abortions and related services at Navy medical facilities.	Direct care medical facilities.
6320/5. .	Serious/Very Serious Condition or Death of Patient on Ward.	To notify activities and next-of-kin of a change in patient's status.	Medical activities providing inpatient care.
6320/7. .	Health Care Staffing Report	See BUMEDINST 6320.16 series.	NMC command medical facilities providing patient care (less hospitals).
6320/8* .	Hospital Staffing Report.do . . . . .	. . . . .do	Hospitals and medical clinics.
6320/9* .	Dependent Eligibility for Medical Care.	Certifies medical care eligibility of dependents who do not have a valid DD 1173 in their possession but have previously been issued one.	Medical and dental activities.
6320/10 .	Statement of Civilian Medical/Dental Care.	See NMCINST 6320.1 series	All activities.

6320/11 .	Newborn Identification.	See BUMEDINST 6320.45 series.	Medical activities providing obstetrical care.
6320/15* .	Established Child Abuse/Neglect Report.	See BUMEDINST 6320.57 series.	Hospitals & med. clinics.
6320.15A* .	Suspected Child Abuse/Neglect/Sexual Assault and Rape Report.	. . . .do	Do.
6320/16 .	Recovery Room Record.	To provide a comprehensive record of care and treatment received by patients in the postanesthesia recovery room.	Do.
6320/18 .	Binnacle List	See art. 23-51.	Activities having medical personnel.
6320/19 .	Morning Report of Sick and Injured	See art. 23-52.	Do.
6320/20+ .	Birth Certificate	See BUMEDINST 6320.59 series.	Hospitals and medical clinics providing obstetrical care.
6320/21* .	Established Spouse Abuse/Neglect Report.	See BUMEDINST 6320.57 series.	Hospitals and medical clinics.
6320/23 .	Health Benefits Advisor Workload.	To evaluate data to determine which HBAs are performing at maximum level.	Health benefits advisor offices, naval Medical Department facilities.
6320/28 .	Credentials Action Report	To provide a medium for reporting credentials review information data. (See NMCNOTE 6320 (latest issuance).)	Naval hospitals and medical clinics.

* Stocked in COMNAVMECOM.

+ To be printed by using activities using the format provided by BUMEDINST 6320.59 series. Name and seal of using activity to be inserted as indicated.

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NAVMED	Title	Function	Using Activities
6320/29 .	Credentials Reappraisal Report (RCS 6320-38).	See NMCINS1 6320.8 series.	Naval hospitals and medical clinics.
6410/1. .	Grounding Notice (Aeromedical). . .	See art. 15-78.	Aviation activities having medical personnel.
6410/2. .	Clearance Notice (Aeromedical). . .	See art. 15-77.	Do.
6410/3* .	Aerospace Physiology Training Report.	See art. 14-16.	Aviation activities utilizing aerospace physiology train- ing devices for training purposes.
6410/4* .	Altitude Chamber Reaction Report. . . . .	. . . .do	Aerospace physiology training activities.
6410/5. .	Student Screening Form. . . . .	. . . .do	Do.
6410/6* .	Aerospace Physiology Training Agreement.	See art. 14-16.	Do.
6410/7. .	Completion of Training Certificate. . . . .	. . . .do	Do.
6410/8. .	Aerospace Physiology Training and Low Pressure Chamber Flight Log.	. . . .do	Aviation activities utilizing aerospace physiology train- ing devices for training purposes.
6410/9. .	Anthropometric Data Record.	To obtain anthropometric measurements on all aviation candidates.	Ships and stations having a flight surgeon or aviation medical examiner.

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6470/1 .	Exposure to Ionizing Radiation. . .	See NAVMED P-5055, Radiation Health Protection Manual.	Activities having personnel occupationally exposed to sources of ionizing radiation and not having electronic data processing equipment.
6470/3* .	Thermoluminescent Dosimetry Evaluation.	See NAVMED P-5055, Radiation Health Protection Manual.	Activities having personnel occupationally exposed to sources of ionizing radiation and utilizing lithium fluoride thermoluminescent dosimetry.
6470/4 .	Medical/Dental X-Ray Equipment Data.	To obtain information on the location, type, and function of diagnostic X-ray equipment in the Navy.	All fleet and shore activities having medical/dental diagnostic X-ray equipment.
6470/5 .	General Requirements for Radiographic Equipment.	To determine if the radiographic X-ray equipment is performing within accepted standards for performance and safety.	Do.
6470/6 .	Performance Tests for Radiographic Equipment.	To determine if the radiographic X-ray equipment is performing within accepted standards.	Do.
6470/7 .	General Requirements and Performance Tests for Fluoroscope Equipment.	To determine if the fluoroscope X-ray equipment is performing within accepted standards for performance and safety.	All activities having fluoroscopic X-ray equipment.
6470/8 .	Radiographic Quality Assurance and Protection Programs.	To determine if a facility has a radiographic quality assurance program and a radiation protection program.	All fleet and shore activities having medical/dental diagnostic X-ray equipment.
6470/9 .	Radiation Protection Survey	To determine the adequacy of structural radiation barriers.	Do.

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23-60. Tabulation of Medical Department Forms--Continued

NAVMED	Title	Function	Using Activities
6520/8*	Antarctic Assignment Questionnaire.	See BUMEDINST 6520.1 series	Activities screening personnel for Antarctic duty.
6520/9*	Psychiatric Evaluation--Operation Deep Freeze.	. . . .do	Medical activities having psychiatrists assigned.
6520/10*	Psychological Evaluation--Operation Deep Freeze.	. . . .do	Medical activities having psychologists assigned.
6520/11*	Combined Evaluation--Operation Deep Freeze.	. . . .do	Medical activities having psychologists and psychiatrists assigned.
6530/1. .	Blood Bank Operational Report . . .	See arts. 14-10 and 14-11	Activities having blood banks.
6550/2. .	Ward Report	See NAVMED P-5066, Nursing Procedures Manual.	Ships and stations providing inpatient care.
6550/3. .	Twenty-Four Hour Nursing Service Report.	. . . .do	Do.
6550/4. .	Medication and Treatment Card . . .	. . . .do	Do.
6550/5. .	Medication and Treatment Card PRN .	. . . .do	Do.
6550/6. .	Inquiry, School of Nursing.	To obtain personal and professional references incident to appointment in Nurse Corps USNR.	Navy Nurse Corps officers will provide to affected schools of nursing.
6550/7. .	Intravenous Certification	See BUMEDINST 6550.3 series	Medical activities having Nurse Corps officers and/or civilian nurses.

6550/8. .	Medication Administration Record. .	To provide a complete, concise profile of a patient's past and present medications.	Medical activities providing inpatient care.
6550/12 .	Patient Profile	To provide a reference to demographic and therapeutic data used in patient care.	All health care facilities which have inpatient capabilities.
6550/13 .	Patient Care Plan	To provide a format for establishing discharge objectives referral activities, problems, expected outcomes reevaluation dates, and nursing actions/orders. (See NAVMED P-5066, Nursing Procedures Manual.)	Ships and stations providing inpatient care.
6550/14 .	Patient Data Base	To provide patient data which will serve as a basis for identifying patient problems. (See NAVMED P-5066, Nursing Procedures Manual.)	Do.
6600/3 .	Dental Health Questionnaire	See art. 6-157A	Ships and stations having dental personnel.
6600/4 .	Navy Periodontal Screening Examination.	See art. 6-157B	Do.
6600/5 .	Dental Appointments, Daily.	See art. 6-153.	Ships and stations having a dental officer.
6600/6 .	Dental Appointment.	Patient's record of dental appointment. .	Do.
6600/8 .	Dental Information Retrieval System (DIRS) Treatment Provided Report.	See NMCINST 6600.1 series	Naval dental clinics.
6600/9A .	DIRS Treatment Required Report.do	Do.

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23-60. Tabulation of Medical Department Forms-Continued

NAV MED	Title	Function	Using Activities
6600/10. .	DIRS Personnel Onboard Report	See NMCINST 6600.1 series	Naval dental clinics.
6600/11. .	DIRS Individual Daily Treatment Report.	. . . .do	Do.
6630/2. .	Precious Metal Issue Record	See art. 6-155.	Activities having dental prosthetic facilities.
6630/3. .	Statement and Inventory of Precious and Special Dental Metals.	See art. 6-156.	Do.
6630/5. .	Orthodontic Index and Evaluation of Occulsion.	To determine the severity of the malocclusion and to set priorities for initiating orthodontic care for the eligible dependents.	Specified branch dental.
6630/6. .	Orthodontic Transfer Form Patient in Active Treatment.	For referral between treating orthodontists.	Do.
6630/7. .	Special Consent to Performance of Orthodontic Treatment.	Medico-legal form ensuring orthodontic patient awareness of nature of treatment procedure and responsibilities of the parties involved.	Do.
6700/1* .	Supply Workload Summary	See NAVMED P-5020, Resource Management Handbook.	Hospitals and medical clinics.
6700/2* .	Medical/Dental Local Purchases. . .	See BUMEDINST 6700.20 series.	Hospitals, medical/dental clinics, and NAVENPVNTMEDU's.
6700/3* .	Medical Equipment Maintenance Record.	To document complete maintenance history on in-use equipment.	Ships and stations having medical/dental equipment.

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6700/4* .	Medical Maintenance Work Order. . .	To request maintenance or other work on equipment.	Do.
6700/5. .	Conductivity Test Record.	To record conductivity tests performed. .	Ships and stations having operating and delivery rooms.
6700/6* .	Manufacturers Item Identification .	See BUMEDINST 6700.20 series.	Hospitals, medical/dental clinics, and NAVENPVNTMEDU's.
6700/7. .	Microwave Oven Survey Instrument Information.	To provide specific identifying information concerning microwave ovens prior to annual calibration of instruments.	All Navy ships/activities having microwave survey instruments.
6710/1. .	Narcotic and Controlled Drug Account Record.	See arts. 21-28, 21-29, 21-42, and 21-45 and NMCINST 6710.4 series.	Ships and stations having medical/dental officers, podiatrists, or independent duty Hospital Corps personnel authorized to prescribe controlled substances.
6710/2* .	Investigational Drug Data Record . .	See NMCINST 6710.4 series.	Hospitals, medical/dental clinics, and NMC command RDT&E research facilities.
6710/3* .	Investigational Drug Inventory and Prescription Record.	. . . .do	Do.
6710/4. .	Narcotic and Controlled Drug Inventory-24 Hour.	See arts. 21-28, 21-42, and 21-45	Ships and stations having medical/dental officers, podiatrists, or independent duty Hospital Corps personnel authorized to prescribe controlled substances.
6710/5. .	Perpetual Inventory of Narcotics, Alcohol, and Controlled Drugs.	See arts. 21-42 and 21-45	Do.

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23-60. Tabulation of Medical Department Forms--Continued

NAVMED	Title	Function	Using Activities
6710/6. .	Polyprescription.	See arts. 21-5, 21-41, and 21-45.	Ships and stations having medical/dental personnel authorized to prescribe drugs.
6710/8. .	Request for Emergency Use of Investigational Drug, Device, or Biologic.	See NMCINST 6710.4 series	Do.
6710/9. .	Investigational Drug Status Report. . . . .	. . . .do	Do.
6710/10 .	Polyprescription-- Limited. . . . .	. . . .do	Do.
6710/11 .	Prescription--Limited . . . . .	. . . .do	Do.
6750/4. .	Dental Equipment and Facilities Report.	See NMCINST 6750.1 series	All facilities having dental treatment spaces.
6760/0-9.	Medical X-ray Film Jacket	See BUMEDINST 6760.1 series	Ships and stations having X-ray facilities.
6770/1* .	Linen Inventory	See NMCINST 6770.1 series	Hospitals and medical clinics.
7220/1* .	Statement of Intent	To indicate intention to participate or not to participate in Variable Incentive Pay Program if eligible. (See SECNAVINST 7220.61 series.)	NMC and effected activities having medical officers.
7220/2* . (NAVCOMPT 2184).	Continuation Pay Designation and Acceptance.	See SECNAVINST 7220.61 series.	Do.
7300/2. .	Record of Discounts and Adjustments/Partial Delivery/Partial Liquidation.	See NAVMED P-5020, Resource Management Handbook.	Hospitals and medical clinics (except New London).

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7300/9. .	Military Services Detail Code Sheet	See NAVMED P-5020, Resource Management Handbook.	Hospitals and medical clinics.
7300/11 .	RMS Posting Advice/Memorandum . . .	Provides control of accounting entries.	Do.
7300/12 .	RMS Posting Advice/Memorandum . . .	. . . .do	Do.
7300/14*.	General Purpose Ledger Sheet. . . .	See NAVMED P-5020, Resource Management Handbook.	Nonmechanized hospitals and medical clinics.
7302/1* .	RMS Register No. 10 Code Sheet. . .	. . . .do	Nonmechanized NMC command activities.
7302/2* .	RMS Register No. 71 Code Sheet. . .	. . . .do	Do.
7302/3* .	EOB No. 1 Card Code Sheet . . . . .	. . . .do	Do.
7302/4* .	EOB No. 2 Card Code Sheet . . . . .	. . . .do	Do.
7302/6* .	EOB No. 3 Card Code Sheet . . . . .	. . . .do	Do.
7302/7* .	Hospital Subsistence Report . . . . .	. . . .do	Hospitals and medical clinics.
7302/8* .	RMS Register No. 61 Code Sheet. . .	To record accounting data	NMC command activities without key punch equipment.
7310/1* .	Cost Summary Record	See NAVMED P-5020, Resource Management Handbook.	NMC command activities without ADP capability.
7502/2. .	General Journal . . . . .	. . . .do	Hospitals and medical clinics.
7520/1. .	Collection Agent Accountability . .	See BUMEDINST 7520.1 series	Do.
10110/2 .	Food Service Performance Analysis .	See BUMEDINST 10110.2 series.	Do.
12410/1*.	Jango Certificate	To certify completion of the Nurse's Aide Training Course for Junior Army Navy Guild Organization.	COMNAVMEDCOM.

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23-61. Tabulation of Standard Federal Forms

SF	Title	Function	Using Activities
47. . . .	Inquiry for Motor Vehicle Operators Physical Fitness.	Provides medical information related to physical fitness of actual or prospective motor vehicle operators.	Activities providing care to civilian employees.
78. . . .	Certificate of Medical Examination.	Records medical examination of applicants and the opinion of the examining physician as to physical capability to perform duties.	Do.
88. . . .	Report of Medical Examination . . .	See chapter 15 and arts. 16-37 thru 39 and BUMEDINST 5360.1 series.	Ships and stations having medical/dental officers.
91A . . .	Investigation Report of Motor Vehicle Accident.	See BUMEDINST 5100.6 series	NMC command activities.
93. . . .	Report of Medical History	See chapter 15 and arts. 16-41 and 42. . .	Activities having a medical officer.
120 . . .	Report of Excess Personal Property.	See BUMEDINST 4500.2 series	Activities having medical/dental personnel.
135 . . .	Records Transmittal and Receipt . .	To transfer records to record centers . .	Activities retiring records to record centers.
135A. . .	Records Transmittal and Receipt (Continuation).	. . . .do	Do.
177 . . .	Statement of Physical Ability for Light Duty Work.	Provides information concerning the physical ability of applicants for certain light duty work positions.	Activities providing care to civilian employees.
217 . . .	Medical Report (Epilepsy)	To determine individual's ability to perform assigned duties.	Do.

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23-61. Tabulation of Standard Federal Forms-Continued

SF	Title	Function	Using Activities
502 . . .	Narrative Summary	Summarizes the salient facts regarding a patient's hospitalization. Include one copy in the patient's clinical record. See art. 16-66.	Activities providing inpatient care.
503 . . .	Autopsy Protocol.	See art. 17-2	Do.
504 . . .	History-Part 1.	Records history of present illness, including nature and duration of complaints and circumstances of admission. Include in patient's clinical record.	Do.
505 . . .	History-Parts 2 and 3	Part 2 records patient's past history, including occupation, military history, habits, family history, childhood, and adult injuries. Part 3 records a general system review. Include in patient's clinical record.	Do.
506 . . .	Physical Examination.	Records patient's physical and mental characteristics, particularly appearance of specified parts of body. Include in patient's clinical record.	Do.
507 . . .	Continuation Sheet.	Serves as a continuation sheet for any other standard medical form.	Ships and stations providing patient care.
508*. . .	Doctor's Orders	Records doctor's orders for patient's care and treatment. Include in patient's clinical record.	Ships and stations providing inpatient care.
509 . . .	Progress Notes.	Enables the doctor and others to post information on the progress made by a patient during hospitalization. Include in patient's clinical record.	Do.

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510 . . .	Nursing Notes	Records medications and treatments given to patient by a nurse, including pertinent observations. Include in patient's clinical record.	Do.
511 . . .	Temperature-Pulse-Respiration (Fahrenheit).	Records temperature, pulse, and respiration observations and other data. Include in patient's clinical record.	Do.
512 . . .	Plotting Chart.	Pictures in graphic form such phases of hospitalization as a patient's progress or reactions to a specific treatment. Include in patient's clinical record.	Do.
512A. . .	Plotting Chart-Blood Pressures. . .	Shows blood pressure in graphic form. Include in patient's clinical or outpatient record.	Activities providing patient care.
513 . . .	Consultation Sheet.	See art. 16-67.	Do.
515 . . .	Tissue Examination.	Records facts pertaining to the examination of a tissue specimen, including a pathological report. Include in patient's clinical record.	Do.
516 . . .	Operation Report.	Records pertinent and identifying data regarding a patient's operation. Include in patient's clinical or outpatient record.	Do.
517 . . .	Anesthesia.	Records in chart and narrative form the administration of an anesthesia, including a preoperative and postoperative review. Include in patient's clinical or outpatient record.	Do.
518 . . .	Blood or Blood Component Transfusion	Records the elements involved in giving a blood transfusion to a patient, including certification, cross-matching, reaction, etc. Include in patient's clinical or outpatient record.	Do.

23-61. Tabulation of Standard Federal Forms-Continued

SF	Title	Function	Using Activities
519 . . .	Radiographic Reports.	Serves as a backing sheet to hold radiographic reports. Include in patient's clinical or outpatient record.	Activities having X-ray facilities.
519A. . .	Radiographic Reports.	Requests, reports on, and records the results of a radiographic examination. Staple to SF 519.	Do.
520 . . .	Electrocardiographic Record	Records pertinent facts and results pertinent to an electrocardiographic examination. Include in patient's clinical or outpatient record.	Activities providing electrocardiographic tests.
522 . . .	Request for Administration of Anesthesia and for Performance of Operations and Other Procedures.	Obtains authorization for the administration of anesthesia, the performance of operations or other procedures, the disposal of tissues or parts which may be removed, and the photographing or televising of procedures and tissue for the advancement of knowledge. This form is required for all personnel. Include in patient's clinical or outpatient record.	Activities providing patient care.
523 . . .	Authorization for Autopsy	See art. 17-2	Do.
523A. . .	Disposition of Body	Receipt for and certificate of release of a deceased body at a morgue.	Activities having a morgue.
523B. . .	Authorization for Tissue Donation .	Obtains authorization for tissue donation.	Activities providing patient care.
524 . . .	Radiation Therapy	Provides a record of radiation therapy treatment performed. Include in patient's clinical or outpatient record.	Activities providing radiation therapy treatment.

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525 . . .	Radiation Therapy Summary	Provides a summary of roentgen therapy treatment performed. Include in patient's clinical or outpatient record.	Do.
526 . . .	Interstitial/Intercavitary Therapy.	Provides a record of interstitial/intercavitary therapy treatments performed. Include in patient's clinical or outpatient record.	Do.
527 . . .	Medical Record--Group Muscle Strength, Joint R.O.M. Girth and Length Measurements.	Records manual muscle evaluation. Include in patient's clinical or outpatient record.	Activities providing patient care.
528 . . .	Muscle and/or Nerve Evaluation--Manual and Electrical: Upper Extremity	Records muscle and/or nerve evaluation, manual and electrical, of the upper extremity. Include in patient's clinical or outpatient record.	Do.
529 . . .	Muscle and/or Nerve Evaluation--Manual and Electrical: Trunk, Lower Extremity, Face.	Records muscle and/or nerve evaluation, manual and electrical, of the trunk, lower extremity, and face. Include in patient's clinical or outpatient record.	Do.
530 . . .	Neurological Examination.	Records neurological examination. Include in patient's clinical or outpatient record.	Do.
531 . . .	Anatomical Figure	Depicts anatomical figure. Include in patient's clinical or outpatient record.	Do.
533 . . .	Prenatal and Pregnancy.	Records prenatal and pregnancy examinations, including past histories and a complete physical examination. Include in patient's clinical or outpatient record.	Activities providing prenatal and pregnancy examinations.

23-61. Tabulation of Standard Federal Forms-Continued

SF	Title	Function	Using Activities
534 . . .	Labor	Records labor history and post partum examinations. Include in patient's clinical record.	Activities providing inpatient care.
535 . . .	Newborn	Provides a complete record for the newborn, including method of delivery, initial physical examination, condition upon discharge from hospital, and followup examinations. Include in patient's clinical record.	Do.
536 . . .	Pediatric Nursing Notes	Records pediatric nursing notes. Include in patient's clinical record.	Do.
537 . . .	Pediatric Graphic Chart	Pictures certain phases of a newborn's hospitalization in graphic form. Include in patient's clinical record.	Do.
538 . . .	Pediatric	Provides a complete pediatric history, including family or contact history, record of immunization, past medical and surgical history, and education. Include in patient's clinical or outpatient record.	Activities providing pediatric care.
539 . . .	Abbreviated Medical Record.	See art. 16-66A	Ships and stations providing patient care.
541 . . .	Gynecologic Cytology.	Records facts pertaining to vaginal and cervical cytology examinations. Include in patient's clinical or outpatient record.	Activities providing patient care.
542 . . .	Specimen Record	See NAVMED P-5083, Methods for Preparing Pathological Specimens for Storage and Shipment.	Medical activities.

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543 . . .	Contributor's List of Pathologic Material.do	Do.
544 . . .	Statement of Patient's Treatment. .	Provides information to other medical activities about treatment provided to a patient.	Do.
545 . . .	Laboratory Report Display	Serves as a backing sheet to which SF's 546-557 are attached.	Activities having laboratory facilities.
546 . . .	Chemistry I	Requests, reports on, and records various subtests relative to a chemistry examination.	Do.
547 . . .	Chemistry II. . . . .	. . . .do	Do.
548 . . .	Chemistry III (Urine)	Requests, reports on, and records various subtests relative to a chemistry examination.	Do.
549 . . .	Hematology.	Requests, reports on, and records various subtests relative to a hematology examination.	Do.
550 . . .	Urinalysis.	Requests, reports on, and records various subtests relative to a urinalysis examination.	Do.
551 . . .	Serology.	Requests, reports on, and records various subtests relative to a serology examination.	Do.
552 . . .	Parasitology.	Requests, reports on, and records various subtests relative to a parasitology examination.	Do.
553 . . .	Microbiology I.	Requests, reports on, and records various subtests relative to a microbiology examination.	Do.
554 . . .	Microbiology IIdo	Do.

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23-61. Tabulation of Standard Federal Forms--Continued

SF	Title	Function	Using Activities
555 . . .	Spinal Fluid.	Requests, reports on, and records various subtests relative to a spinal fluid examination.	Activities having laboratory facilities.
556 . . .	Immunohematology.	Requests, reports on, and records various subtests relative to an immunohematology examination.	Do.
557 . . .	Miscellaneous	Requests, reports on, and records results of miscellaneous examinations.	Do.
558 . . .	Emergency Care and Treatment. . . .	See BUMEDINST 6320.61 series.	Activities having medical personnel.
600 . . .	Chronological Record of Medical Care	See arts. 6-119, 16-44 thru 16-48	Ships and stations having medical personnel.
601 . . .	Immunization Record	See arts. 16-49 thru 16-51.	Do.
602 . . .	Syphilis Record	See arts. 16-52 and 16-53	Activities having medical personnel.
603 . . .	Dental.	See arts. 6-107 thru 6-118 and BUMEDINST 5360.1 series.	Ships and stations having a dental officer.
603A. . .	Dental-Continuation	Continuation sheet for SF 603	Do.
1034. . .	Public Voucher for Purchases and Services Other Than Personal.	See BUMEDINST 6322.6 series	Ships and stations.
1080. . .	Voucher for Transfers Between Appropriations and/or Funds.	To bill for reimbursement of patient care provided.	Activities having a collection agent.
2824C . .	Physician's Statement	Provides medical information by the attending physician to support application for disability retirement.	Activities providing care to civilian employees.

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23-62. Tabulation of Department of Defense Forms

DD	Title	Function	Using Activities
7	Report of Treatment Furnished Pay Patients-Hospitalization Furnished (Part A).	See NMCINST 6320.3 series.	Activities providing inpatient care to supernumeraries.
7A. . . .	Report of Treatment Furnished Pay Patients-Outpatient Treatment Fur-ished (Part B).	. . . .do	Activities providing out-patient care to supernumeraries.
113	Military Pay Record	See NAVMED P-5020, Resource Management Handbook.	Medical clinics and hospitals.
139	Pay Adjustment Authorization. . . .	. . . .do	Do.
183	Request for Clinical Follow-up Information.	See BUMEDINST 6150.32 series.	Medical or dental officers desiring followup infor-mation on patients trans-ferred prior to completion of treatment or final disposition.
214. . . .	Separation from Active Duty.	See BUMEDINST 6320.11 series.	All ships & stations.
398	Personnel Security Questionnaire.	See SECNAVINST 1500.8 series.	Ships and stations.
448	Military Interdepartmental Purchase Request.	See NAVMED P-5020, Resource Management Handbook.	NMC command activities.
509. . . .	Inspection Record of Prisoner in Segregation.	See NMCINST 6320.11 series	Hospitals and medical and dental clinics.

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23-62. Tabulation of Department of Defense Forms-Continued

DD	Title	Function	Using Activities
551 . . .	Record of Interment	See NAVMED P-5016, Handling of Deceased Personnel in Theaters of Operations.	Activities involved in processing/interring remains.
565 . . .	Statement of Recognition.	See BUMEDINST 5360.1 series	All ships & stations.
567 . . .	Record of Recovery of Remains . . .	See NAVMED P-5016, Handling of Deceased Personnel in Theaters of Operations.	Activities involved in recovering/processing remains.
568 . . .	Grave Plot Chart. . . . .	. . . .do	Activities involved in processing/interring remains.
572 . . .	DOD Military Blood Program-Blood Donor Record.	For use in national emergency and when directed by NMC. May be used currently by any medical activity which collects blood, if desired.	Armed services blood donor centers. Any blood collecting activity, if desired.
573 . . .	Shipping Inventory of Blood Collections.	For use in national emergency and when directed by NMC.	Do.
599 . . .	Patient's Effects Storage Tag . . .	Local control of personal effects retained in bag room. May serve as a signed receipt for clothing and effects returned to patient.	Activities providing inpatient care.
600 . . .	Patient's Baggage Tag	See BUMEDINST 4650.2 and 4650.7 series.	Activities that air-evac patients.
601 . . .	Patient Evacuation Manifest	See BUMEDINST 4650.2 series	Do.
602 . . .	Patient Evacuation Tag. . . . .	. . . .do	Do.
675 . . .	Receipt for Records and Patient's Property.	See BUMEDINST 6320.11 series.	Activities in contiguous U.S.

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686 . . .	Fluoride/Bacteriological Examination of Water.	See BUMEDINST 6240.3 series	Ships and stations.
689 . . .	Individual Sick Slip.	See arts. 16-70 thru 16-73.	Ships having Medical Department personnel.
710 . . .	Physical and Chemical Analysis of Water	See BUMEDINST 6240.3 series	Ships and stations.
739-1. .	Register of Patients Alphabetic. .	To record patients in alphabetic sequence.	Do.
771 . . .	Eyewear Prescription.	See BUMEDINST 6810.4 series	Do.
780-1. .	Inventory Record.	See NMCINST 6780.1 series and art. 16-69.	Do.
792 . . .	Nursing Service-Twenty-Four Hour Patient Intake and Output Worksheet.	To maintain standardized records of patient's intake and output.	Do.
877 . . .	Request for Medical/Dental Records or Information.	See art. 23-54.	Do.
890 . . .	Record of Identification Processing (Effects and Physical Data).	See NAVMED P-5016, Handling of Deceased Personnel in Theaters of Operations.	Activities involved in identification and processing remains.
891 . . .	Record of Identification Processing-Dental Chart.	See BUMEDINST 5360.1 series	Do.
892 . . .	Record of Identification Processing-Skeletal Chart.do	Do.

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23-62. Tabulation of Department of Defense Forms-Continued

DD	Title	Function	Using Activities
893 . . .	Record of Identification Processing- Anatomical Chart.	See BUMEDINST 5360.1 series	Activities involved in identification and processing remains.
894 . . .	Record of Identification Processing- Fingerprint Chart.	. . . .do	Do.
895 . . .	Disinterment Record	See NAVMED P-5016, Handling of Deceased Personnel in Theaters of Operations.	Activities involved in processing/interring remains.
896 . . .	Field Search Record . . . . .	. . . .do	Activities involved in identification/processing remains.
1074. . .	Questionnaire of Local Inhabitants Regarding Deceased Personnel.	. . . .do	Do.
1075. . .	Convoy List of Remains. . . . .	. . . .do	Do.
1076. . .	Record of Personal Effects-Military Operations.	. . . .do	Do.
1077. . .	Register of Remains . . . . .	. . . .do	Do.
1078. . .	Plot Roster of Disinterments. . . . .	. . . .do	Activities involved in processing/interring remains.
1079. . .	Cemetery Register . . . . .	. . . .do	Do.
1131. . .	Cash Collection Voucher	See NAVMED P-5020, Resource Management Handbook.	NMC command activities.

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1141. . .	Record of Occupational Exposure to Ionizing Radiation.	See arts. 16-61 thru 16-63 and NAVMED P-5055, Radiation Health Protection Manual.	Ships and stations having medical personnel.
1149. . .	Requisition and Invoice/Shipping Document.	See BUMEDINST 5360.1 series	Activities involved in processing/shipping remains.
1155. . .	Order for Supplies or Services/ Request for Quotations.	. . . .do	Activities involved in identification and processing remains.
1191. . .	Warning Tag for Medical Oxygen Equipment.	See BUMEDINST 5100.1 series	Ships and stations having medical/dental personnel.
1251. . .	Nonavailability Statement, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).	See NMCINST 6320.3 series	Activities providing patient care.
1289. . .	DOD Prescription.	See chapter 21.	Activities having medical/ dental officers, civilian physicians, podiatrists, and independent duty Hospital Corps personnel.
1322. . .	Aircraft Accident Autopsy Report. .	See NAVMED P-5065, Autopsy Manual	Ships and stations having a medical officer.
1323. . .	Toxicological Examination-Request and Report.	. . . .do	Do.
1342. . .	DOD Property Record	See BUMEDINST 11240.4 series and NAVMED P-5020, Resource Management Handbook.	NMC command activities.
1348. . .	DOD Single Line Item Requisition System Document (Manual).	See NMCINST 1510.2 series	Do.

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23-62. Tabulation of Department of Defense Forms-Continued

DD	Title	Function	Using Activities
1351-2. .	Travel Voucher or Subvoucher. . . .	See BUMEDINST 5360.1 series	Activities involved in processing/shipping remains.
1375. . .	Request for Payment of Funeral and/or Interment Expenses.	. . . .do	Hospitals, medical clinics, and other activities providing Decedent Affairs Program services.
1380. . .	U.S. Field Medical Card	See NAVMED P-5016, Handling of Deceased Personnel in Theaters of Operations.	Activities having medical personnel.
1384. . .	Transportation Control and Movement Document.	See BUMEDINST 5360.1 series	Activities involved in processing/shipping remains.
1387-2. .	Special Handling Data/Certification	. . . .do	Do.
1425. . .	Specifications and Standards Requisition.	See NMCINST 1510.2 series	NMC command activities.
1473. . .	Report Documentation Page	See art. 20-5(5) and SECNAVINST 3900.24 series.	RD&E activities submitting research and development reports.
1494. . .	Application for Frequency Allocation.	See OPNAVINST 2300.45 and OPNAVINST 2410.11 series.	Activities requesting a frequency allocation for communication-electronic equipment.
1498. . .	Research and Technology Work Unit Summary.	See arts. 20-5(4) and 20-6(4) and BUMEDINST 3900.3 series.	Activities managing and conducting RD&E.

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1502. . .	Frozen Medical Material Shipment. .	To mark containers packed with perishable frozen medical material items.	Medical material activities.
1502-1. .	Refrigerated Medical Material Shipment.	To mark containers packed with perishable refrigerated medical material items.	Do.
1502-2. .	Limited Unrefrigerated Medical Material Shipment.	To mark containers packed with perishable medical material items that are shipped out of refrigeration, but should be refrigerated upon receipt.	Do.
1574. . .	Serviceable Tag-Materiel.	See BUMEDINST 6700.36 series.	Do.
1575. . .	Suspended Tag-Materiel. . . . .	. . . .do	Do.
1577. . .	Unserviceable (Condemned) Tag-Materiel	. . . .do	Do.
1577-2. .	Unserviceable (Reparable) Tag-Materiel	. . . .do	Do.
1826. . .	Certificate of Competency	See BUMEDINST 6250.12 series.	NMC provides to affected activities.
1826-1. .	Certificate of Competency (Wallet Size).	. . . .do	Do.
1839. . .	Baggage Identification Tag.	See BUMEDINST 4650.7 series	Activities that air-evac patients.
2005. . .	Privacy Act Statement-Health Care Records.	All-inclusive Privacy Act statement for health care records.	Ships and stations.
2062. . .	Record of Preparation & Disposition of Remains (Outside CONUS).	See BUMEDINST 5360.1 series	Do.
2063. . .	Record of Preparation & Disposition of Remains (Inside CONUS).	. . . .do	Do.

23-62. Tabulation of Department of Defense Forms--Continued

DD	Title	Function	Using Activities
2064. . .	Certificate of Death (Overseas) . . .	See arts. 17-3 thru 17-5.	Medical Department activities outside the 50 United States and the District of Columbia.
2065. . .	Disposition of Remains--Reimbursable Basis.	See BUMEDINST 5360.1 series	Ships and stations.
2161. . .	Referral for Civilian Medical Care.	See NMCINST 6320.3 series	Medical treatment facilities.
2214. . .	Noise Survey.	See OPNAVINST 6260.2 series	Ships and stations having medical personnel.
2215. . .	Reference Audiogram . . . . .	. . . .do	Do.
2216. . .	Hearing Conservation Data	See OPNAVINST 6260.2 series	Ships and stations having medical personnel.
2217. . .	Biological Audiometer Calibration Check.	. . . .do	Do.

23-63. Tabulation of Other Prescribed Forms

Form No.	Title	Function	Using Activities
CA 1 & 2*	Federal Employee's Notice of Injury or Occupational Disease.	Notifies official superior of injury/occupational disease and furnishes the official superior's report to OWCP (Office of Worker's Compensation Programs).	Activities treating civilian employees.
CA 2a* . .	Notice of Recurrence of Disability	Notifies OWCP that an employee, after returning to work, is again disabled due to a prior injury or occupational disease previously reported.	Do.
CA 3* . . .	Report of Termination of Total or Partial Disability; Report of Death.	Notifies OWCP that disability from injury has terminated; or notifies OWCP when employee dies as a result of the injury.	Do.
CA 4* . . .	Claim for Compensation on Account of Injury or Occupational Disease.	Claims compensation when injury results in (1) loss of pay for more than 3 days or (2) permanent disability or disfigurement or (3) loss of wage earning capacity.	Do.
CA 4a* . .	Application for Augmented Compensation for Disability.	Claims additional compensation in total disability situations.	Do.
CA 5* . . .	Claim for Compensation on Account of Death.	Claims compensation when injury results in death.	Do.
CA 5b* . .	Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren.	Claims compensation for these dependents when injury results in death.	Do.
CA 7* . . .	Claim for Compensation on Account of Traumatic Injury.	Claims compensation based on a traumatic injury.	Do.

See footnotes at end of table.

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23-63. Tabulation of Other Prescribed Forms-Continued

Form No.	Title	Function	Using Activities
CA 8* . . .	Claim for Continuance of Compensation on Account of Disability.	Claims compensation when loss of pay continues beyond the time covered by the original claim on Form CA 4.	Activities treating civilian employees.
CA 16* . . .	Request for Examination and/or Treatment.	See NMCINST 6320.3 series.	Do.
CA 17* . . .	Duty Status Report.	In instances of trauma, provides supervisor and OWCP with brief interim medical statement concerning employee's ability to return to any type of work.	Activities treating civilian employees.
CA 20* . . .	Attending Physician's Report. . . .	See NMCINST 6320.3 series.	Do.
CA 20a* . .	Attending Physician's Supplemental Report.	Provides OWCP with additional medical information to support claim filed on Form CA 8.	Do.
CHAMPUS 500	CHAMPUS/CHAMPVA Claim Form.	See SECNAVINST 6320.8 series.	Medical and dental treatment facilities.
CDC 9.2936A	Venereal Disease Epidemiologic Report	See NAVMED P-5052.11A, Treatment and Management of Venereal Disease.	Medical treatment facilities.
CNET 7310/12	Per Capita Cost of Training Host Allocation Worksheet for Tenant Costs.	See BUMEDINST 7310.2 series	NMC command activities.
CNET 7310/13	Per Capita Cost of Training Report	. . . .do	Do.
CNET 7310/14	Per Capita Cost of Training Additional Training Support.	. . . .do	Do.

CSC 3178** .	Report of Medical Examination for Disability Retirement.	Records results of medical examination conducted for disability retirement.	Activities treating civil service personnel.
CSC 3684** .	Medical Report (Diabetes Melitus).	Records information as to diabetic condition to assist in determining whether an applicant is physically capable of performing the duties of the position for which application is made.	Do.
CSC 3986** .	Authorization for Release of Medical Records.	Provides employee's authorization for release of medical records.	Do.
DA 1863-1..	Services and/or Supplies Provided by Civilian Hospitals.	See SECNAVINST 6320.8 series.	Medical and dental treatment facilities.
DA 1863-3. .	Services and/or Supplies-Handicapped Program.	. . . .do	Do.
DEA 106+ . .	Report of Theft of Controlled Substances.	See arts. 21-25 and 21-45	Ships and stations having controlled substances.
FAA 8500-8 .	Report of Medical Examination . . .	See art. 15-81(6)	Activities conducting medical examinations for Federal Aviation Administration certification.
FD 258++ . .	Fingerprint Card.	See SECNAVINST 1500.8 series.	Ships and stations.
FD 1571++ . .	Notice of Claimed Investigational Exemption for a New Drug.	See NMCINST 6710.4 series	Medical and dental activities conducting investigational research of new drugs.
FD 1572++ . .	Statement of Investigator (Clinical Pharmacology).	. . . .do	Do.
FD 1573++ . .	Statement of Investigator . . . . .	. . . .do	Do.
FD 1639++ . .	Drug Reaction Report.	To report significant drug reactions.	Medical and dental treatment facilities.

See footnotes at end of table.

23-63. Tabulation of Other Prescribed Forms-Continued

Form No.	Title	Function	Using Activities
FD 2579++ .	Report of Assembly of a Diagnostic X-ray System.	See BUMEDINST 6700.36 series.	Ships and stations having X-ray equipment.
FD 2609++ .	Blood Bank Inspection Checklist and Report.	See BUMEDINST 6530.13 series.	Medical clinics and hospitals in the contiguous United States.
GAO 3010◇ .	Informal Inquiry.	See NAVMED P-5020, Resource Management Handbook.	Activities having disbursing officers.
HSM 13.19 (CDC)	Maritime Public Health Declaration.	See SECNAVINST 6210.2 series.	Military or public health quarantine inspectors in U.S. ports.
HSM 43 . . .	Authorization for Contract or Non-Contract Hospitalization-Indian Health Activities.	See NMCINST 6320.3 series	Medical treatment facilities.
HSM 159. . .	Treatment Authorization . . . . .	. . . .do	Do.
MSC 12010-3	Continuous Record and Training. . .	See SECNAVINST 4061.1 series.	Ships and stations having civilian marine personnel of the Military Sealift Command.
NAVCOMPT 140	Work Request.	See NAVMED P-5020, Resource Management Handbook.	NMC command activities.
NAVCOMPT 252	Navy Bill . . . . .	. . . .do	Do.
NAVCOMPT 261	Journal Voucher	See NAVMED P-5020, Resource Management Handbook.	Do.

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NAVCOMPT 274	Report of Minor Property.do	Do.
NAVCOMPT 632	Accounting Card	See NMCINST 6320.1 series	Ships and stations.
NAVCOMPT 634	Listing of Expenditures/Collections	See NAVMED P-5020, Resource Management Handbook.	NMC command activities.
NAVCOMPT 733	General Ledger. . . . .	. . . .do	Do.
NAVCOMPT 752	Unofficial Telephone Subscribers Fund.	. . . .do	Do.
NAVCOMPT 2006	Cash Receipts-USN Housing Project	. . . .do	Do.
NAVCOMPT 2007	Adjustment Slip . . . . .	. . . .do	Do.
NAVCOMPT 2008	Refund Request/Account Adjustment- USN Housing Project.	. . . .do	Do.
NAVCOMPT 2010	Tenants Ledger Card . . . . .	. . . .do	Do.
NAVCOMPT 2025	Status of Fund Authorizations . . .	. . . .do	Do.
NAVCOMPT 2036	Reconciliation Report (Expenditures/ Collections).	. . . .do	Do.
NAVCOMPT 2044	Funded Reimbursable Work Estimate .	. . . .do	Do.
NAVCOMPT 2053	Project Orderdo	Do.
NAVCOMPT 2054	Unofficial Telephone Service.do	Do.

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23-63. Tabulation of Other Prescribed Forms-Continued

Form No.	Title	Function	Using Activities
NAVCOMPT 2160	Public Voucher for Medical Services	See NMCINST 6320.1 series	Ships and stations.
NAVCOMPT 2164	Reimbursable Work Order Record. . .	See NAVMED P-5020, Resource Management Handbook.	NMC command activities.
NAVCOMPT 2165	Cash Disbursement Journal . . . . .	. . . .do	Do.
NAVCOMPT 2166	Reimbursable Orders Received Journal	. . . .do	Do.
NAVCOMPT 2167	Job Order Cost Summary. . . . .	. . . .do	Do.
NAVCOMPT 2168-1	Resource Authorizations . . . . .	. . . .do	Dental clinics.
NAVCOMPT 2171	Budget Classification/Functional Category/Expense Element Report.	. . . .do	NMC command activities.
NAVCOMPT 2182	Military Services Report. . . . .	. . . .do	Do.
NAVCOMPT 2199	Trial Balance Report. . . . .	. . . .do	Do.
NAVCOMPT 7010/2	Resources Expended in Support of NAF Activities.	See NAVMED P-5020, Resource Management Handbook.	Do.
NAVCRUIT 1100/1	Application for Commission Form . .	See SECNAVINST 1500.8 series.	Ships and stations.

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NAVCUIT 1100/13	Interviewer's Appraisal Sheet . . .	See BUMEDINST 1120.40 series.	Medical clinics, hospitals, and recruiting offices.
NAVEXOS 110	Quarterly Accident Data Report (Military and Civilian Personnel).	See BUMEDINST 5100.6 series	NMC command activities.
NAVEXOS 5100/7	Quarterly Motor Vehicle Accident Summary.	. . . .do	Do.
NAVFAC 11200/28	Annual Allowance and Requirements Review.	See BUMEDINST 11240.4 series.	Do.
NAVFAC 11200/29	Replacement Justification--Annual Requirements Review.	. . . .do	Do.
NAVJAG 5890/12	Hospital and Medical Care 3rd Party Liability Case.	See BUMEDINST 5890.1 series and NMCINST 6320.3 series.	Medical and dental treatment facilities.
NAVPERs 1306/7	Enlisted Transfer and Special Duty Request.	See art. 12-8(3).	NMC command activities.
NAVPERs 5510/1	Record Identifier for Personnel Reliability.	See art. 16-2	Ships and stations having medical/dental personnel.
NAVPERs 5521/3	Certificate of Completion of Security Investigation.	See SECNAVINST 1500.8 series.	Ships and stations.
NAVSO 7410/1	Monthly Report of Civilian Employment by Appropriation.	See BUMEDINST 7410.1 series	NMC command activities.

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23-63. Tabulation of Other Prescribed Forms-Continued

Form No.	Title	Function	Using Activities
NAVSUP 154	Survey Request, Report and Expenditure	See art. 6-149.	Dental facilities.
NDW/NNMC 6143/2A	Deposit/Withdrawal Data	See art. 14-4(2).	Medical clinics and hospitals.
OF 23# . . .	Charge Out Record	See BUMEDINST 6150.1 series	Ships and stations having medical personnel.
OF 24# . . .	Shelf File Chargeout Record (Letter Size).	. . . .do	Activities having medical personnel.
OF 25# . . .	Shelf File Chargeout Record (Legal Size).	See BUMEDINST 6760.1 series	Medical clinics and hospitals.
OPNAV 3750/1	Aircraft Accident Report.	See BUMEDINST 5100.11 series.	Aeromedical safety officers.
OPNAV 3750/8A thru 81	Medical Officers Reports. . . . .	. . . .do	Do.
OPNAV 5100/1	Accident Injury/Death Report. . . .	See BUMEDINST 5100.6 series	NMC command activities.
OPNAV 5100/2	Accident Damage Reports for Naval Property Ashore.	. . . .do	Do.
OPNAV 5100/9	Dispensary Permit	See OPNAVINST 5100.14 series.	Activities treating civilian employees.
OPNAV 5210/41	Records Management Improvement Recommendations.	OPNAVINST 5210.15 series.	Ships and stations.

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PHS-731	International Certificates of Vaccination.	See art. 16-51 and BUMEDINST 6230.1 series.	Ships and stations having medical personnel.
PHS-732	Deratting or Deratting Exemption Certificate.	See BUMEDINST 6250.7 series	Medical Department officers designated as Public Health Service officers.
VA 07-4582□	Button and String Envelope.	See BUMEDINST 6320.11 series.	Medical treatment facilities.
VA 10-10□	Application for Medical Benefits. .	See BUMEDINST 6320.11 series and NMCINST 6320.3 series.	Do.
VA 10-10M□	Medical Certificate and History . .	See NMCINST 6320.3 series	Do.
VA 10-1000□	Narrative and Diagnostic Summary. .	See BUMEDINST 6320.11 series.	Do.
VA 10-1204□	Referral for Community Nursing Home Care.	. . . .do	Do.
VA 21-526□	Veterans Application for Compensation and Pension.	. . . .do	Do.
VA 21-526E□	Claim for Compensation, Pension or Hospitalization.	See BUMEDINST 6150.31 series.	Ships and stations having medical personnel.
VA 21-534□	Application for Dependency and Indemnity Compensation by Widow or Child.	See BUMEDINST 6320.11 series.	Medical treatment facilities.
VA 21-535□	Application for Dependency and Indemnity Compensation by Parent.	. . . .do	Do.
VA 23-8426□	Flash Notice.	See BUMEDINST 6150.31 series.	Ships and stations having medical personnel.

23-63. Tabulation of Other Prescribed Forms-Continued

Form No.	Title	Function	Using Activities
VA 29-357 □	Claim for Disability Insurance Benefits.	See SECNAVINST 1741.12 series	Ships and stations.
VA 29-888 □	Insurance Deduction Authorization. . . . .	. . . .do	Do.
VA 40-1330 □	Application for Headstone or Marker.	See BUMEDINST 5360.1 series	Activities providing decedent affairs services.

LEGEND

- * CA forms are available from the U.S. Department of Labor, Washington, DC 20210.
 - ** CSC forms are available from the Office of Personnel Management, Washington, DC 20415.
 - + DEA forms are available from Drug Enforcement Agency offices.
 - ++ FD forms are available from the Food and Drug Administration, Bethesda, MD 20205.
 - ◇ GAO forms are available from the General Accounting Office, Washington, DC 20548.
 - # OF forms are available from General Services Administration supply depots.
 - VA forms are available from Veterans Administration Regional Offices.
- All other forms are available from the Navy Supply System.

Section III. RELEASE OF INFORMATION FROM RECORDS

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23-70. General

(1) SECNAVINST 5211.5 series implements the Privacy Act of 1974 (PL 93-579) 5 USC 552a within the Department of the Navy. The Surgeon General has been designated the official responsible for administering and supervising the execution of SECNAVINST 5211.5 series as it pertains to the Health Care Treatment Record System. Additionally, the Surgeon General is the official authorized to deny requests of individuals for notification, access, and amendment to their medical and dental records. The Head, Administrative Services Branch (MEDCOM-312) has been designated as the Privacy Act Coordinator within the Naval Medical Command.

(2) Commanding officers and officers in charge of Navy and Marine Corps activities are designated as local system managers for individual health care records maintained and serviced within their activities. Custodians of individual health care records are responsible for familiarizing themselves with SECNAVINST 5211.5 series and complying with the provision for preserving the privacy of information concerning individuals contained in departmental health care records. Generally, these provisions are:

(a) To permit individuals to know what records pertaining to them are collected, maintained, used, or disseminated, to have access to and have copies made of all or any portions of their records, and, subject to the provisions of article 23-73, to obtain amendment of such records when a discrepancy is noted.

(b) To permit individuals to prevent records pertaining to themselves, obtained for a particular purpose, from being used or made available for another purpose without their consent.

(c) To require the collection, maintenance, use, or dissemination of records of identifiable personal information only for necessary and lawful purposes and to ensure that such information is current and accurate for the intended uses.

(d) To ensure that adequate safeguards are provided to prevent misuse of personal information in records.

(e) To ensure that requests of individuals for notification, access, disclosure, or amendment concerning their records are acted on as promptly as is feasible. In the event a local systems manager deems that an individual's request for notification, access, disclosure, or amendment should be denied, the request and all supporting documentation, including a copy of the medical or dental treatment

record in question, shall be promptly forwarded to COMNAVMEDCOM (MEDCOM-312).

23-71. Release of Medical Information

(1) Local system managers are authorized to release information from health care records physically located within the command in accordance with the provisions of this article and article 23-74. The requesting office or individual shall be advised that such information is considered to be of a private and confidential nature and directed to treat it accordingly.

(2) The information necessary to accomplish the legitimate purpose for which required and, if so required, a complete transcript of the member's or former member's health care records may be furnished in accordance with the following policy guidelines:

(a) Release to the Public.-Information contained in health care records of individuals who have undergone medical or dental examination or treatment is personal to the individual and is therefore considered to be of a private and confidential nature. Consequently, information from such health care records, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy, should not be made available to the public. Such information is exempt from release under the Freedom of Information Act.

(b) Release to the Individual Concerned.-Release of health care information to the individual concerned falls within the purview of the Privacy Act and not the Freedom of Information Act. If individuals request information from their health care record, it shall be released to them unless, in the opinion of the releasing authority, it might prove injurious to their physical or mental health. In such an event, and where the circumstances indicate it to be in their best interests, the individuals shall be requested to authorize the release of the information to their personal physician.

(c) Release to Representatives of the Individual Concerned.-Health care information shall be released to authorized representatives of the individual concerned, upon the written request of the individual or the individual's legal representative. If the individual concerned is mentally incompetent, insane, or deceased, the next of kin or legal representative must authorize, in writing, the release of the individual's health care records. Next of kin or legal representative must submit adequate proof that the member or former member has been declared mentally incompetent or insane, or furnish adequate proof of death in instances where such information is not on file. Legal representatives must also provide proof of appointment such as a certified copy of the court order of appointment.

(d) Release to Other Government Departments and Agencies.-Health care information shall be released, upon request, to other departments and agencies which have a proper and legitimate need for the information as listed in the "Routine uses" section of the Health Care Treatment Records System promulgated by the current SECNAVNOTE 5211, subj; Systems of Personal Records Authorized for Maintenance under the Privacy Act of 1974, 5 USC 552a (PL 93-579). (Note: Publication of the list will be annually as a SECNAVNOTE in the 5211 series.)

(1) Should the releasing authority have doubts of whether the requesting department has a proper and legitimate need for the information, the latter will be requested to specify the purpose for which the health care information will be used. When appropriate, the requesting department will be advised that the information will be withheld until it obtains the written consent of the individual concerned.

(2) In honoring proper requests, the releasing authority shall disclose only that information which is germane to the request. The following are representative instances where other departments and agencies, both Federal and State, may have a proper and legitimate need for the information.

(a) Health care information is required in order to process a governmental action involving the individual whose health care record is sought. (The Veterans Administration and the Office of Workers' Compensation Programs process claims in which the claimant's medical or dental history is relevant.) In those instances where an agency requests health care information solely for employment purposes, a written authorization from the individual concerned shall be required.

(b) Health care information is required in furtherance of the treatment to an individual in the department's custody. (Federal and State hospitals and prisons may need the medical or dental history of their patients and inmates.)

(c) Release to Federal or State Courts or Other Administrative Bodies.—The foregoing limitations are not intended to preclude compliance with lawful court orders calling for the production of health care records in connection with civil litigation or criminal proceedings, nor to preclude release of information from health care records when required by law.

(1) Health care records of Navy personnel (military, civilian employees, and others) may be produced in Federal, State, or territorial courts, including local courts, upon order of the court where litigation is pending. In such an instance, authority need not be obtained from the Navy Department. The records shall be subject to current restrictions on release of classified information and subject to the exception noted in article 23-71(4) with respect to release of medical information concerning civilian employees. When certified copies of records are produced, they shall be forwarded direct to the clerk of the court issuing the order.

(2) Whenever the releasing authority has doubts of whether the subpoena or other compulsory process has been issued by a court of competent jurisdiction or by a responsible officer of any agency or body having power to compel production, the Judge Advocate General of the Navy (or other cognizant legal officer) shall be consulted.

(f) Copies of Health Care Records.—Upon request, an individual or an authorized representative entitled to have access to health care records, will be furnished copies of the individual's health care records. The provisions of article 23-71(2)(b) shall apply in those instances where release of the requested information might prove injurious to the member's physical or mental health.

(3) Commanding officers of Medical Department treatment facilities are authorized to release information from health care records physically located within the command to members of their staff who are conducting research projects. Where possible the names of patients should be deleted. All other requests from research groups will be forwarded to COMNAVMECOM for appropriate action.

(4) Release of medical reports or information concerning civilian appointees or employees is controlled by the provision of the Federal Personnel Manual, section 339.1-4.

(5) Attention is invited to pertinent articles in U.S. Navy Regulations and the JAG Manual for additional information concerning the release of information from naval medical or dental records.

23-72. Disclosure Accounting

(1) Each activity shall, with respect to the individual health care records it maintains, keep an accurate accounting of the date, nature, and purpose of each disclosure of a record to any person or other agency, and the name and address of the person or agency to whom the disclosure is made. The only exceptions to this accounting requirement are for disclosures made to personnel of the Department of the Navy and personnel of the Department of Defense who have a need for the record in the performance of their duties which is compatible with the purpose for which the record is maintained, and for disclosures made of those records required to be released under the Freedom of Information Act.

(a) An accounting is required for disclosures outside the Department of Defense, even when such disclosure is with the written consent, or at the request of, the individual.

(b) The purpose of the accounting is to:

(1) Allow individuals to determine to whom their records have been disclosed.

(2) Provide a basis for subsequently advising recipients of records of any disputed or corrected records.

(3) Provide an audit trail for subsequent review of activity compliance.

(c) A record of each disclosure made will be included as an integral part of an individual's health care record. In those instances where the transaction is accomplished by mail, the record will include the request/authorization and a copy of the activity's forwarding transmittal form or letter. When the disclosure is made by personal review, the record will consist of a copy of the request or authorization to review the record, a signed, dated statement that the review was accomplished, and a listing or description of any copies made of the record.

23-73. Amendment Procedures

(1) The Privacy Act of 1974 as implemented by SECNAVINST 5211.5 series provides for individuals to request amendment of their personal records when the individuals believe the records to be inaccurate, irrelevant, untimely, or incomplete. The Commander, Naval Medical Command as the designated denial authority has established the following rules for amendment of health care records:

(a) Requests must be in writing and must indicate that they are being made under the Privacy Act or SECNAVINST 5211.5 series. Requests should contain sufficient information to locate the particular record which the requestor is seeking to amend. A request should also contain a statement of the changes desired in the record, the reasons for requesting amendment, and any

available information the requestor can provide in support of the request, including pertinent documents and related records.

(b) Requests should be submitted to the local systems manager (holder of the records in question) who shall provide the requestor with written acknowledgment of receipt within 10 working days after the request has been received. The acknowledgment should clearly identify the request and advise the individual when the individual may expect notification of the action taken on the request. No separate acknowledgment of receipt is required if the request can be acted on within the 10 working day period.

(c) If the local systems manager determines that the individual's request for amendment is warranted, a correcting entry shall be made in the appropriate record showing wherein and to what extent the original entry is erroneous. The original entry shall not be stricken out. Local systems managers are not authorized to effect deletions from health care records. The systems manager shall advise previous recipients of the record for whom a disclosure accounting has been made that the record has been amended, and of the substance of the correction.

(d) If the local systems manager determines that any portion or all of a request for amendment is not warranted or if the action to amend the record requires deletion of the record, the request shall be forwarded with recommendations and related information (including a copy of the record which is the subject of the request) to COMNAVMEDCOM (MEDCOM-312).

23-74. Show of Authority

(1) Prior to the furnishing of information, granting disclosures, or authorizing amendment of records noted in article 23-71, a proper show of authority must be established in regard to each request. The application may be made in person or by mail but must be reduced to writing.

23-75. Personal Liability (Penalty)

(1) **Maintaining Personal Records.**—It is unlawful to maintain systems of records about individuals without prior announcement in the Federal Register. Anyone who does is subject to criminal penalties up to \$5,000. Even with such notice, care shall be taken to keep only such personal information as is necessary to do what law and the President, by executive order, require. The information is to be used only for the purpose described in the Federal Register.

(2) **Disclosure.**—Information about an individual shall not be disclosed to any unauthorized individual. Anyone who makes an unauthorized disclosure on purpose may be fined up to \$5,000. Every member or employee of the Department of the Navy who maintains records about individuals has an obligation to do ones part in protecting personal information from unauthorized disclosure. SECNAVINST 5211.5 series describes when disclosures are authorized.

23-76. Annual Report

(1) COMNAVMECOM command activities shall submit the annual report (DD(A) 1379 (5211)) required by paragraph 14 of SECNAVINST 5211.5 series to COMNAVMECOM (MECOM-312) no later than 1 February of each year. Medical Department representatives, ashore and afloat, shall submit data to the appropriate denial authority in the chain of command as specified in paragraph 4c of SECNAVINST 5211.5 series.

23-77. Death Forms for Civilian Agencies and Individuals

(1) All requests received from next of kin, relatives, insurance agencies, companies, fraternal organizations, etc., for completion of blank forms relative to deaths of military or civilian personnel in naval medical facilities, except in Veterans Administration situations, shall be satisfied locally, by furnishing the

information requested after authorization has been received from the next of kin. If the information is not available locally the request should be referred to COMNAVMECOM for action. In most instances, the inquiry can be satisfied by furnishing a statement of proof of death or a copy of the terminal narrative summary.

(2) Requests for completion of such forms in situations of beneficiaries of the Veterans Administration shall be forwarded to the Manager of the Veterans Administration Regional Office authorizing the admission of the patient.

23-78. Clinical Records to Armed Forces Institute of Pathology

(1) Commanding officers of Medical Department treatment facilities are authorized to furnish original clinical records to the Armed Forces Institute of Pathology (AFIP) upon request. A teaching hospital may reproduce any records considered to be of value for use in residency training, research, or clinical investigation before the original records are sent.

(2) A chargeout card shall be substituted in the clinical record file for each record furnished the AFIP. If a clinical record on loan to the AFIP is not returned prior to scheduled date of retirement, the chargeout card shall be retired along with other eligible clinical records. Clinical records returned after retirement date shall be retired as soon as practicable and in accordance with SECNAVINST 5212.5 series.

23-79. Health Care Records for Use in a Medical Care Recovery Act Claim

(1) When approved by the commanding officer, Medical Department officers may release copies of health care records or other medical or dental information to any JAG designee as designated in 2401(b) of the JAG Manual for the purpose of pursuing a Medical Care Recovery Act Claim (chap. XXIV,

JAG Manual). The responsibility for proper release of health care records in such instances shall rest with the JAG designee or the JAG and shall be restricted to those health care records directly related to treatment of the conditions which gave rise to the claim. Requests for other health

care records of the member concerned shall be processed in accordance with article 23-71.

(2) When a subpoena for health care records is received, the appropriate JAG designee shall be consulted and the records released in accordance with their instructions.

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